

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2004

P703

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

RALPH REGULA, Ohio, Chairman

C. W. BILL YOUNG, Florida
ERNEST J. ISTOOK, JR., Oklahoma
ROGER F. WICKER, Mississippi
ANNE M. NORTHUP, Kentucky
RANDY "DUKE" CUNNINGHAM, California
KAY GRANGER, Texas
JOHN E. PETERSON, Pennsylvania
DON SHERWOOD, Pennsylvania
DAVE WELDON, Florida
MICHAEL K. SIMPSON, Idaho

DAVID R. OBEY, Wisconsin
STENY H. HOYER, Maryland
NITA M. LOWEY, New York
ROSA L. DeLAURO, Connecticut
JESSE L. JACKSON, JR., Illinois
PATRICK J. KENNEDY, Rhode Island
LUCILLE ROYBAL-ALLARD, California

NOTE: Under Committee Rules, Mr. Young, as Chairman of the Full Committee, and Mr. Obey, as Ranking
Minority Member of the Full Committee, are authorized to sit as Members of all Subcommittees.

CRAIG HIGGINS, SUSAN ROSS FIRTH, MEG THOMPSON, SUE QUANTIUS,
FRANCINE MACK-SALVADOR, and NICOLE KUNKO, *Subcommittee Staff*

PART 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	Page
Secretary of Health and Human Services	1
Bioterrorism and Other Public Health Emergencies	531
Centers for Medicare and Medicaid Services	703
Administration for Children and Families	1203
Administration on Aging	1867
Special Tables	2043

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES
APPROPRIATIONS FOR 2004

KF6221
AS
US
2003h
pt.2

HEARINGS
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED EIGHTH CONGRESS
FIRST SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

RALPH REGULA, Ohio, *Chairman*

C. W. BILL YOUNG, Florida
ERNEST J. ISTOOK, Jr., Oklahoma
ROGER F. WICKER, Mississippi
ANNE M. NORTHUP, Kentucky
RANDY "DUKE" CUNNINGHAM, California
KAY GRANGER, Texas
JOHN E. PETERSON, Pennsylvania
DON SHERWOOD, Pennsylvania
DAVE WELDON, Florida
MICHAEL K. SIMPSON, Idaho

DAVID R. OBEY, Wisconsin
STENY H. HOYER, Maryland
NITA M. LOWEY, New York
ROSA L. DELAURO, Connecticut
JESSE L. JACKSON, Jr., Illinois
PATRICK J. KENNEDY, Rhode Island
LUCILLE ROYBAL-ALLARD, California

NOTE: Under Committee Rules, Mr. Young, as Chairman of the Full Committee, and Mr. Obey, as Ranking
Minority Member of the Full Committee, are authorized to sit as Members of all Subcommittees.

CRAIG HIGGINS, SUSAN ROSS FIRTH, MEG THOMPSON, SUE QUANTIUS,
FRANCINE MACK-SALVADOR, and NICOLE KUNKO, *Subcommittee Staff*

PART 2
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary of Health and Human Services	Page 1
Bioterrorism and Other Public Health Emergencies	531
Centers for Medicare and Medicaid Services	703
Administration for Children and Families	1203
Administration on Aging	1867
Special Tables	2043

Printed for the use of the Committee on Appropriations

U.S. GOVERNMENT PRINTING OFFICE

COMMITTEE ON APPROPRIATIONS

C. W. BILL YOUNG, Florida, *Chairman*

RALPH REGULA, Ohio	DAVID R. OBEY, Wisconsin
JERRY LEWIS, California	JOHN P. MURTHA, Pennsylvania
HAROLD ROGERS, Kentucky	NORMAN D. DICKS, Washington
FRANK R. WOLF, Virginia	MARTIN OLAV SABO, Minnesota
JIM KOLBE, Arizona	STENY H. HOYER, Maryland
JAMES T. WALSH, New York	ALAN B. MOLLOHAN, West Virginia
CHARLES H. TAYLOR, North Carolina	MARCY KAPTUR, Ohio
DAVID L. HOBSON, Ohio	PETER J. VISCLOSKEY, Indiana
ERNEST J. ISTOOK, Jr., Oklahoma	NITA M. LOWEY, New York
HENRY BONILLA, Texas	JOSE E. SERRANO, New York
JOE KNOLLENBERG, Michigan	ROSA L. DELAURO, Connecticut
JACK KINGSTON, Georgia	JAMES P. MORAN, Virginia
RODNEY P. FRELINGHUYSEN, New Jersey	JOHN W. OLVER, Massachusetts
ROGER F. WICKER, Mississippi	ED PASTOR, Arizona
GEORGE R. NETHERCUTT, Jr., Washington	DAVID E. PRICE, North Carolina
RANDY "DUKE" CUNNINGHAM, California	CHET EDWARDS, Texas
TODD TIAHRT, Kansas	ROBERT E. "BUD" CRAMER, Jr., Alabama
ZACH WAMP, Tennessee	PATRICK J. KENNEDY, Rhode Island
TOM LATHAM, Iowa	JAMES E. CLYBURN, South Carolina
ANNE M. NORTHUP, Kentucky	MAURICE D. HINCHEY, New York
ROBERT B. ADERHOLT, Alabama	LUCILLE ROYBAL-ALLARD, California
JO ANN EMERSON, Missouri	SAM FARR, California
KAY GRANGER, Texas	JESSE L. JACKSON, Jr., Illinois
JOHN E. PETERSON, Pennsylvania	CAROLYN C. KILPATRICK, Michigan
VIRGIL H. GOODE, Jr., Virginia	ALLEN BOYD, Florida
JOHN T. DOOLITTLE, California	CHAKA FATTAH, Pennsylvania
RAY LAHOOD, Illinois	STEVEN R. ROTHMAN, New Jersey
JOHN E. SWEENEY, New York	SANFORD D. BISHOP, Jr., Georgia
DAVID VITTER, Louisiana	MARION BERRY, Arkansas
DON SHERWOOD, Pennsylvania	
DAVE WELDON, Florida	
MICHAEL K. SIMPSON, Idaho	
JOHN ABNEY CULBERSON, Texas	
MARK STEVEN KIRK, Illinois	
ANDER CRENSHAW, Florida	

JAMES W. DYER, *Clerk and Staff Director*

**DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RE-
LATED AGENCIES APPROPRIATIONS FOR
2004**

THURSDAY, MARCH 20, 2003.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

WITNESS

HON. TOMMY THOMPSON, SECRETARY

Mr. REGULA. Good morning, Mr. Secretary. We are delighted to have you here.

We have about five minutes. Mr. Secretary, why don't you make your opening statement and then we will have to recess for votes. We will be a total of about 25 minutes because we have three votes but we have a little time before we need to leave. How much time do you need?

Secretary THOMPSON. I was going to take ten minutes but if you want me to just summarize some things.

Mr. REGULA. Why don't you summarize and that way we will come back and start the question period.

[The justification follows:]

STATEMENT

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES

LABOR/ HHS/ ED APPROPRIATIONS SUBCOMMITTEE

TOMMY G. THOMPSON

SECRETARY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

March 20, 2003

Good morning Mr. Chairman, Congressman Obey and members of the committee. I am honored to be here today to present to you the President's FY 2004 budget for the Department of Health and Human Services (HHS). I am certain you will find that, viewed in its entirety, our budget will help improve the health and safety of our Nation. Before I discuss the FY 2004 budget, I would like to thank the committee for its hard work and dedication to the programs at HHS.

Our FY 2004 request totals \$539 billion in outlays, approximately 7.3 percent over the FY 2003 budget. The discretionary budget authority portion of the HHS budget, before this committee, totals \$60.7 billion, which is an increase of approximately \$1.5 billion, or 2.6 percent over the FY 2003 President's Budget and an increase of approximately \$514 million, or 0.9 percent over the FY 2003 enacted appropriation. Mandatory outlays for HHS total \$475.9 billion in this budget proposal, an increase in excess of 7 percent.

The budget proposed by the President for HHS will enable the Department to continue its important work with our partners at the State and local levels and the newly created Department of Homeland Security. Working together, we will hold fast to our commitment to protecting our Nation and ensuring the health and well-being of all Americans. Many of our programs at HHS provide necessary services that contribute to fighting the war on terrorism and provide us with a more secure future. And, I am particularly focused on preparedness at the State and local level, HHS's ability to respond rapidly to a bioterrorist attack, research on and development of vaccines and other therapies to counter potential bioterrorist attacks, and ensuring the safety of our food supply.

The President's FY 2004 budget request also continues to support the needs of the American people by strengthening and improving Medicare and Medicaid; enhancing Temporary Assistance for Needy Families (TANF) and Foster Care; strengthening the Child Support Enforcement Program; and furthering the reach of the President's New Freedom Initiative.

The support of your committee is vital to achieving many of the Administration's most important priorities. I am grateful for the close partnership we have enjoyed in the past, and I look forward to working with you again on an aggressive appropriations agenda to advance the health and well being of millions of Americans. Today, I would like to highlight for you the key issues in the President's budget.

Supporting the President's Disease Prevention Initiative

One of the most important issues on which we can work together is chronic disease prevention. We all have heard the disturbing news about the prevalence of diabetes, obesity, and asthma that could be prevented through simple lifestyle changes. The statistics, I am sure, are as alarming to you as they are to me. For example, the incidence of diabetes and obesity among Americans is up sharply in the past decade, putting millions more Americans at higher risk for heart disease, stroke and other related medical conditions.

Diabetes alone costs the Nation nearly \$132 billion each year in direct medical costs and in indirect economic costs, including disability, missed work, and premature death. Medical studies have shown that modest lifestyle changes -- such as getting more exercise and losing weight -- can reduce an individual's risks for developing this serious health conditions.

The HHS budget, consistent with the President's HealthierUS effort, proposes a coordinated, Department-wide endeavor – Steps to a HealthierUS – to promote healthier lifestyles emphasizing prevention of obesity, diabetes, asthma, heart disease, stroke, and cancer. The FY2004 budget includes an investment of \$125 million for targeted disease prevention.

Improving the Nation's Health

Of all the issues confronting this Department, none has a more direct impact on the well being of our citizens than the health of our Nation. Our budget makes a concerted effort to improve the health of the American people by taking significant steps that include: reducing prescription drug-related medical costs, financing vaccines, investing in hospital information technology, and continuing the effort to increase and expand the number of Health Centers.

The budget includes initiatives that will carry out the Best Pharmaceuticals for Children Act (BPCA) and alleviate drug-related medical costs. My budget request for NIH includes an additional \$25 million, for a total of up to \$50 million, to improve information available for prescribing pharmaceuticals to children. NIH is focusing its efforts on drugs that are no longer under patent. The request for the Food and Drug Administration (FDA) includes \$12.3 million to increase Americans' access to safe, effective, and less expensive generic drugs and a \$1 million increase to expand the range of drugs available over-the-counter.

The HHS budget includes a series of improvements in the financing of childhood vaccines to meet three goals -- 1) improve vaccine access for currently eligible children, 2) restore tetanus and diphtheria booster vaccines (Td, DT) to the Vaccines for Children (VFC) program, and 3) build a national stockpile of childhood vaccines. Legislation will be proposed to improve access to VFC vaccines for children already entitled to them. The budget proposes to expand the number of access points for underinsured children – those whose private insurance does not cover the immunizations – by allowing them to receive their VFC vaccines at State and local public health clinics. To help protect against future shortages, HHS will, starting in FY 2003, develop a stockpiling strategic plan and begin building a vendor-managed, 6-month supply of all childhood vaccines to be completed by 2006. The budget includes \$707 million in FY 2003 to 2006 for the stockpile. Under current-law we can stockpile these vaccines. I also propose to restore the tetanus and diphtheria booster shots to the VFC program by removing outdated price caps that are so low for some vaccines that vendors will not bid on VFC contracts.

The budget also contains \$100 million to ensure the nation has an adequate supply of influenza vaccine in the event of a pandemic. Due to the constant changes in the circulating influenza strains, we cannot stockpile influenza vaccine, and the current manufacturing methods could not meet the Nation's needs in the event of a pandemic. Funds will be used for activities to ensure a year-round influenza vaccine production capacity and the development and implementation of rapidly expandable production technologies. We will work closely with industry to accomplish these goals.

Patient safety is a major focus of AHRQ's research portfolio and instrumental in reducing medical costs. In FY 2001, we made awards to 94 grantees in five areas to begin the first of three years of research to improve patient safety across healthcare settings. Nearly half of these demonstration projects are focusing on the use of computers and information technology to

prevent medical errors and to improve reporting of medical errors data. Through these projects, grantees are piloting potential error-reducing technologies like personal digital assistants (PDAs) for electronic prescription writing, as well as Computerized Physician Order Entry (CPOE), a technology that helps to ensure that patients receive the right medication, at the right dose, at the right time. As a result of these projects, AHRQ's first step in improving patient safety has been to demonstrate the efficacy of certain interventions in reducing medical errors.

Our next step must be to take what we have learned and disseminate it to healthcare providers and networks. We are putting \$50 million into a new program at AHRQ that will improve patient safety by increasing investments in hospital information technology. We are also making a commitment to help implement these technologies in health systems that otherwise may not be able to make the capital investment. A focus on small community and rural hospitals will help to bridge the so-called "digital divide" by helping these hospitals catch up with those that are further along.

AHRQ's budget proposal also includes \$24 million for ongoing activities such as the work of the Patient Safety Task Force and the Patient Safety Data Reporting System integration efforts, as well as plans to initiate challenge grants and a patient safety improvement corps; a \$10 million increase for the expansion and enhancement of information collected in the US Census Bureau's Current Population Survey; and a \$2 million increase to improve the usability and timeliness of Medical Expenditure Panel Surveys (MEPS) data and help sustain prior year enhancements to the sample size and content of surveys that collect information from medical providers, insurers, and households.

We must do everything within our abilities to address the disparities in health care in this Nation. The FY 2004 budget proposes numerous activities to address and alleviate health inequities. Programs that cut across various HHS agencies strive toward bettering the health of our Nation.

The FY 2004 budget continues the third year of the President's multi-year initiative to expand access to care for millions of Americans especially those who are uninsured. The budget includes \$1.6 billion, a \$122 million increase, to provide primary and preventive health care services to nearly 14 million individuals. Almost 40 percent of the patients treated at health centers have no insurance coverage and many others have inadequate coverage. These health centers are located in our most underserved communities. Over half are in rural America. In support of the Health Center Initiative, the President is also seeking to expand the National Health Service Corps by adding \$42 million to increase the number of health care providers in rural and underserved areas, to a total field strength of 4,300 people; and provide for 2,400 loan repayments and scholarships.

In addition to childhood immunization, the FY 2004 President's budget for the Centers for Disease Control and Prevention (CDC) requests programmatic increases in several areas. I am seeking a \$12 million increase for the breast and cervical cancer program, which supports screenings for low-income, underinsured, and uninsured women between the ages of 50-64, and \$5 million to expand School Health Programs to reduce health risks such as tobacco use, poor eating habits and obesity. The budget also includes an increase of \$10 million for a Public Health Information Network (PHIN) to integrate and expand CDC's existing networks to establish a consistent exchange of information between public health partners.

The Substance Abuse and Mental Health Services Administration's proposed budget is \$3.4 billion, a net program level increase of \$198 million over FY 2003. As part of the President's Drug Treatment Initiative, the budget includes \$200 million in FY 2004, a total of \$600 million over three years, to establish a new competitive State substance abuse voucher program. This program will assist 100,000 Americans in the first year in obtaining the critical alcohol and drug treatment services they need but lack access to. This effort complements existing alcohol and drug abuse treatment programs by providing consumer choice and broadening the base of treatment providers to include more faith-based providers. Through this new program individuals seeking drug and alcohol treatment and support services will be assessed and then receive a voucher to pay for appropriate community treatment programs. This program will require accountability by linking payment to providers to demonstrated treatment effectiveness measured by abstinence from alcohol and drug use after treatment.

The FY 2004 request also includes an increase of \$31 million for the Substance Abuse Block Grant. The Block Grant will provide drug treatment services to 400,000 persons. In the area of mental health, we propose \$107 million, an increase of \$9 million, for Children's Mental Health Services to serve a total of 17,000 children and adolescents with serious mental and emotional disorders along with their families. We are also requesting \$50 million, an additional \$7 million, for Projects for Assistance in Transition from Homelessness to serve a total of 147,000 homeless individuals. These funds link efforts to move homeless individuals off the streets by providing them with mental health services and substance abuse treatment.

FIGHTING HIV/AIDS

HIV/AIDS is one of the most serious challenges facing humanity. No country has been spared. Some have faced widespread devastation. All have citizens whose lives have been destroyed by this horrible disease. Our commitment to ending this pandemic is strong and unwavering. The FY 2004 budget for HHS includes \$6.4 billion in discretionary funds within HHS to combat HIV/AIDS. Within this level is \$680 million to support a variety of efforts to fight HIV/AIDS in developing nations. For example, our budget includes \$150 million to support the Mother-to-Child transmission of HIV/AIDS prevention initiative. This initiative seeks to treat approximately one million women annually in developing countries in order to reduce transmission of HIV to their children by 40 percent. This is an integral part of the President's Emergency Plan for AIDS Relief, which seeks to stem the death toll from AIDS. Currently, demographers project that, absent strong action, life expectancy will fall from 66 to 33 years in Zambia and from 70 to 40 years in Zimbabwe.

The budget also, includes \$2 billion for life sustaining care and services for over 530,000 Americans under the Ryan White CARE Act. The Ryan White programs target our resources toward the development of an effective service delivery system by partnering with States, heavily impacted metropolitan areas, faith-based and community-based providers and academic institutions. Our budget includes \$739 million to provide drug therapies to approximately 159,000 individuals. These funds will provide Americans living with HIV/AIDS a lifeline to care who might otherwise have to choose between expensive medical treatments and other necessities. These funds will help eliminate those difficult decisions.

Maintaining our Investment in Biomedical Research

I commend you, Mr. Chairman, Congressman Obey, and this Subcommittee, for your unwavering commitment to doubling the budget for the National Institutes of Health. After five years of outstanding growth that doubled the NIH budget, the FY 2004 Budget provides a significant investment to ensure that the momentum gained over the last five years is sustained. We have developed a plan that would increase funding for on-going research by about \$2 billion, approximately +7 percent. The FY 2004 budget totals \$27.9 billion, a net increase of \$718 million above the FY 2003 enacted appropriation. Within the NIH Budget, research grows much more rapidly, as a result of redirecting one-time project cost savings into new biomedical research funding. NIH will fund a record number of new and competing research grants. Advances in scientific knowledge have provided the foundation for improvement in public health and have led to enhanced health and quality of life for all Americans. Much of this can be attributed to the groundbreaking work carried on by, and funded by, the National Institutes of Health. Some additional highlights of NIH funding include:

- Over \$15 billion to fund an expected record number of research project grants (at least 10,500 for competing grants and a total of approximately 39,500 grants);
- An increase of \$25 million for a total of \$50 million for pediatric drug use studies;
- An increase of \$50 million for Type 1 diabetes research (\$150 million total in mandatory appropriation); and
- An increase of \$25 million for NIH's new strategic biomedical research "roadmap".

Fighting Bioterrorism

Mr. Chairman, as Americans confront the realities of terrorism and hostilities around us, it is imperative that the Federal Government be prepared to keep our citizens safe and healthy.

HHS's \$3.6 billion bioterrorism budget substantially expands ongoing medical research, strengthens State and local preparedness and targets investments to protect our food supply. State and local public health preparedness activities funded by the Centers for Disease Control and Prevention (CDC) and hospital preparedness efforts supported by the Health Resources and Services Administration (HRSA) would receive a total of \$1.5 billion. The President's proposal significantly increases ongoing biodefense research at the National Institutes of Health (NIH). The budget includes a total of \$1.6 billion for basic research on the biology of microbial agents with bioterrorism potential and applied research on the development of new or improved diagnostics, vaccines, and therapies. We propose increasing support for bioterrorism education for clinicians by \$32 million, for a total of \$60 million, to provide incentives for 25 medical and health professions curricula reform projects and provide continuing education to 65,000 health care providers on the diagnosis, treatment, and reporting of diseases that can be caused by the intentional release of a biological agent. The bioterrorism budget also includes initiatives to improve food safety: \$15.5 million targeted on newly authorized activities, including registration of domestic and foreign food facilities and State grants to improve state food laboratories, monitoring and inspections; and an additional \$5 million for improving information exchange with State food laboratories on food pathogens.

HHS, in cooperation with the Department of Homeland Security, will spearhead the development of Project Bioshield. This project, which the President recently announced, will bring together the scientific and fiscal resources of the United States government in an innovative effort to develop medical countermeasures against bioterror before they are ever needed. Project Bioshield will have three (3) major goals:

- To ensure that sufficient resources are available to procure the next-generation countermeasures. A guaranteed funding source must be available to enable the government to purchase vaccines and other therapies as soon as experts believe they can be made and will be safe and effective, and spur industry investment in the development of these vaccines/therapies..
- To Accelerate NIH research and development. This involves providing more flexible contracting process and procurement authorities for critical biodefense work.
- To make promising treatments available more quickly for use in emergencies. This means establishing a new FDA Emergency Use Authorization that would permit greater flexibility and latitude than the current Investigational New Drug (IND) authority in the use of promising medical countermeasures that are under development in emergency situations.

While funding for the next generation countermeasures will be in the new Department of Homeland Security (DHS), HHS will provide the scientific direction, and will be responsible for the actual procurements. Furthermore, HHS will continue to manage the Strategic National Stockpile and provide the scientific and public health direction needed to ensure that the pharmaceutical stockpiles include appropriate amounts of vaccines, other therapeutics and emergency equipment/supplies. New mandatory funding will also be included in DHS which will ensure that adequate resources are available to procure new medical countermeasures once sufficient research has been conducted to demonstrate that the products will be proven safe and effective. A guaranteed funding source must be made available to industry to stimulate interest and investment in the development of these products. This authority would be invoked only if there is no significant commercial market for the products.

Head Start

Never has there been such a clear commitment on the part of Federal and State governments to enhance the well being of children and families. Never have we known so much about what children need for healthy growth and development. Never have so many programs been focused on meeting these needs of our most vulnerable citizens. There are more resources currently available for low-income children and families than at any other time in our nation's history. The President's budget continues this commitment with a budget of \$6.8 billion to provide 923,000 children Head Start services. However, not all the news is good. Children in Head Start enter school further ahead than other economically disadvantaged children. But unfortunately - even after 30 years - Head Start children do not enter school at the same level as more economically advantaged children.

To strengthen the Head Start program, improve services to low-income children, and promote the coordination and integration of comprehensive early care and education services, President Bush is asking Congress to include in the reauthorization of the Head Start Act a provision that will allow interested states to include Head Start in their preschool plans. Under the President's proposal, states are offered the opportunity to coordinate preschool programs with Head Start programs in exchange for meeting certain accountability requirements. States wishing to participate must submit a state plan that addresses several fundamental issues concerning preschool education.

Faith Based and Community Initiatives

In support of the President's Faith-Based and Community Initiative, the HHS FY 2004 budget supports programs that link faith- and community-based organizations, State and local governments, and Federal partners to provide effective substance abuse treatment and positive youth development.

Another important program that helps some of our most vulnerable children is the Mentoring Children of Prisoners program. We are asking for funds to be increased to a total of \$50 million, which would in turn be made available to faith-based, community-based, state and local governments, tribes, and public organizations for programs that provide supportive one-on-one relationships with caring adults to children who are more likely to succumb to substance abuse, gang activity, early childbearing and delinquency. This down payment will help more than 30,000 adolescent children of prisoners receive guidance, have positive role models, and give them a fighting chance to succeed.

The President's budget also proposes \$20 million for promotion and support of responsible fatherhood and healthy marriages. This funding will promote and support involved, committed, and responsible fatherhood and encourage the formation and stability of healthy marriages.

In addition, the budget request for the Compassion Capital Fund is \$100 million, an increase of \$65 million above the FY 2003 appropriation. These funds would continue to be used to provide technical assistance to faith- and community-based organizations to expand and emulate model social programs.

Strengthening and Improving Medicare

Even though Medicare is not under the jurisdiction of this Committee, we are all aware that our Nation's Medicare program needs to be modernized and improved to provide seniors with more choices and better benefits. While we remain steadfastly committed to ensuring that America's seniors and individuals with disabilities can keep their current, traditional Medicare, the President is dedicating \$400 billion over ten years to provide access to subsidized prescription drug coverage, better private options for those beneficiaries who want them, full coverage for disease prevention, and better protection from high out-of-pocket costs.

Under the President's framework, seniors happy with their coverage under traditional Medicare will be able to keep it, with added protection against high out-of-pocket drug expenses at no additional premium. Seniors who want better coverage will be offered the same types of plan

choices available to members of Congress and federal employees. Private plans will be available in each region of the country, including rural areas. Plans will provide full coverage of preventive care, protection against high out-of-pocket medical costs, and cost sharing that does not penalize the sick. Comprehensive, subsidized prescription drug coverage will be available to those who want it for an additional premium. Low-income seniors will face no premium for drug coverage and will have only nominal cost-sharing requirements. Seniors who enroll in these plans will maintain the ability to choose any doctor and any hospital.

Seniors willing to accept a more selective provider panel will be able to enroll in the same type of low-cost, high-coverage managed care plans available today. These plans will offer a subsidized, comprehensive drug benefit, as well as all the additional benefits I just described. Plans can also offer extra benefits and broader coverage.

Strengthening and Improving Medicaid and SCHIP

State Health Care Partnership Allotments

Another of our mandatory initiatives that I would like to briefly highlight is our plan to strengthen and improve Medicaid and SCHIP. Building on the successes of the State Children's Health Insurance Program (SCHIP) and the Health Insurance Flexibility and Accountability (HIFA) demonstrations have shown in increasing coverage while providing flexibility and reducing the administrative burden on States, the Administration proposes optional State Health Care Partnership Allotments. Under this proposal, States would have the option of electing to continue the current Medicaid program or to choose partnership allotments. The allotment option provides States an estimated \$12.8 billion over seven years in extra funding over the expected growth rate in the current Medicaid and SCHIP budgets. If a State elects the allotments, the federal portion of the SCHIP and Medicaid funding would be combined and states would receive two individual allotments: one for long-term care and one for acute care. States would be required to maintain their current levels of spending on Medicaid and SCHIP, but at a lower rate of increase than the federal allotment.

States electing a partnership allotment would have to continue providing current mandatory services for mandatory populations. For optional populations and optional services, the increased flexibility of these allotments will allow each State to tailor its provision of health benefit packages for its low-income residents. Let me stress that this is an **OPTION** we are proposing for States.

New Freedom Initiative

Promoting home and community-based care as an alternative to nursing homes for the elderly and disabled is a priority of this Administration. The New Freedom initiative represents part of the Administration's effort to allow Americans with disabilities to be more fully integrated into their communities. Under this initiative, we are committed to promoting the use of at-home and community-based care as an alternative to nursing homes. The Administration will invest \$350 million in FY 2004, and \$1.75 billion over 5 years on this important initiative to help seniors and disabled Americans live in the setting that best supports their needs.

Transitional Medicaid Assistance (TMA)

TMA provides health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare-related Medicaid eligibility due to earnings from work. This budget proposal would authorize the TMA program for five more years, at a cost of \$400 million in FY 2004, and \$2.4 billion over five years. We are also proposing modifications to TMA provisions to simplify it and make it work better in coordination with private insurance. These modifications cost \$20 million in FY 2004 and \$290 million over five years.

Empowering America's Families

Reauthorization of Temporary Assistance for Needy Families (TANF) and the Child Care Development Fund

Building on the considerable success of welfare reform in this great Nation, the President's FY2004 budget follows the framework proposed in the FY 2003 request, which includes the reauthorization of TANF. We applaud passage of H.R. 4 and are committed to working with both the House and the Senate to ensure the legislation moves quickly and is consistent with the President's Budget. The President's proposal includes five years of funding for the TANF Block Grants to States, and Tribes; Matching Grants to Territories; and Tribal Work Programs at current levels. In addition, the Budget proposes to reauthorize state-based abstinence education grants for five years at \$50 million annually, to further assist with reducing the number of out-of-wedlock births, reducing the spread of STDs among teens, and helping teens make healthy life choices.

Increasing Support for Children in Foster Care

In a continuing effort to improve the lives of children who are at risk of abuse and neglect, this Administration is proposing a child welfare program option that States can use to improve their child welfare service systems. This plan would allow States to choose a fixed allocation of funds over a five-year period rather than the current entitlement funding for the title IV-E Foster Care program. Participating States would receive their funds in the form of flexible grants which could be used for a wide array of child welfare-related purposes, such as child abuse and neglect prevention, maintenance and administrative payments for foster care, child welfare training, and family support. The flexible funding will allow States to develop innovative ways to ensure the safety, permanency and well-being of children, tailored to meet the needs of their child welfare populations. States which elect this option and experience emergencies affecting their foster care systems may access additional funding from the TANF contingency fund.

The Administration is proposing a nearly \$5 billion budget for Foster Care in FY 2004, a \$90 million increase over last year's request. Not only will these funds support a child welfare program option, but they also will be used to provide payments for maintenance and administrative costs for more than 240,000 children in foster care each month, as well as payments for training and child welfare data systems. The President's budget also requests \$200 million for the Foster Care Independence Program.

Additionally, the Administration continues its commitment to the Promoting Safe and Stable Families Program by requesting to \$505 million to assist States in coordinating services related to child abuse prevention and family preservation. This important program also promotes adoption and provides post-adoption support to families.

Child Support Enforcement

The President's FY2004 budget will build on the considerable success of the Child Support Enforcement program. Legislation will be proposed to enhance and expand the existing automated enforcement infrastructure at the Federal and State level and increase support collected on behalf of children and families. When combined with the opportunities to increase child support outlined in the President's FY2003 budget (expanded passport denial, offset of certain Social Security benefits, optional pass through of child support to families on TANF, among others) these proposals offer an impressive \$7.5 billion in increased child support payments to families over 10 years. The budget also recognizes that healthy families need more than just financial support and increases resources for the Access and Visitation Program to support and facilitate non-custodial parents' access to and visitation of their children.

President's Management Agenda

I realize that as we work to improve the health and well-being of every American citizen, we also need to improve ourselves. I am committed to improving the management of the Department of Health and Human Services. The FY 2004 budget supports the President's Management Agenda and includes cost savings from consolidating administrative functions; organizational delayering to speed decision making processes; competitive sourcing; implementation of effective workforce planning and human capital management strategies; and adoption of other economies and efficiencies in administrative operations. We have also included savings in information technology (IT) which will be realized from ongoing IT consolidation efforts and spending reductions made possible through the streamlining or elimination of lower priority projects. The IT infrastructure consolidation will further reduce infrastructure expenditures for several HHS agencies and should be fully implemented by October 2003.

Improving the Health and Safety of our Nation

Mr. Chairman, the budget I bring before you today contains many different elements of a single proposal. What binds these fundamental elements together is the desire to improve the lives of the American people. All of our proposals, from building upon the successes of welfare reform to protecting the nation against bioterrorism; from increasing access to healthcare, to strengthening Medicare; all these proposals are put forward with the simple goal of ensuring a safe and healthy America. I know this is a goal we all share, and with your support, we are committed to achieving it.

HHS COMMAND CENTER

Secretary THOMPSON. Let me discuss a couple of things I think are interesting and important to this committee. The first is bioterrorism. Because of the incidents of last evening and the fact we are going to war, everybody has some degree of concern about their communities and what is happening as far as bioterrorism is concerned.

I would like to extend an invitation to all of you to come over and see our command headquarters at the Department of Health and Human Services. If you come over, what you would see would allay a lot of fears you might have. In this new command headquarters, we have a computer system that is huge, very fast and has probably the best database of any database in the country and possibly the world. We have all the hospitals listed in our database, all the highways, all the streets in your cities, all your fire stations, all your police stations and all the first responders. We know on a daily basis how many hospital beds you have in a hospital, how many vacancies you have, what kind of hospitals. We are able to develop models for just about any kind of chemical in any community depending on the wind and atmospheric conditions. We also have a meteorologist on duty and we are open 24 hours a day, 7 days a week.

We have teleconferencing capability and I have been involved internationally with the World Health Organization due to the new illness. I would like to talk to you about that in a couple of minutes.

We have the country divided into ten regions, with approximately 8,000 medical personnel, doctors, nurses, morticians as well as veterinarians. We are able to activate them. We have three of our DMED Level 1 teams, our most highly sophisticated ones, 28 of those teams, 2,800 individuals we can call on short notice and be able to direct them to any community in the country.

We have 600 tons of medical supplies and equipment distributed in 12 strategic locations in America which require nine semi-truckloads to haul or one KC-135 but we can make sure they can be transported to any city in America within seven hours. We have Level 1 chemical kits that we have distributed to the major cities and are asking them to put them in their ambulances as well as their fire departments so they can be used immediately if there is chemical exposure.

We also have the capacity that no other place in the world has to hook up to any one of 4,000 local television stations in America. We also just got hooked up with El Jazira in Pakistan. I think this is the only place in the country that has that, so we watch El Jazira, Pakistan and we also have the capacity of hooking up and being able to tap into any one of 4,000 local television stations. If something happened in Topeka, Kansas, we are able to call up local TV stations and watch them while we watch the national news and be able to respond. Our teleconferencing capability gives us the capacity of dealing with ten different groups at the same time and be able to respond immediately.

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

In regards to the disease that all of you are concerned about, we are observing 264 cases right now, 11 of which are in the United States, none of which we have confirmed is the SARS disease. There was an individual from Guangdong Province who became sick when he stayed at the Metropole Hotel outside of Hanoi. There were seven other individuals who became sick on the same floor. They were the eight individuals who fanned out into Hanoi, Singapore, Bangkok and Canada and became sick. It was all traced back to this one hotel. We don't have the common source yet but we are getting it down to that hotel. It was a place where all eight individuals became deathly sick and were on the same floor of the Metropole Hotel which is somewhat interesting.

So far we have not confirmed, and Dr. Weldon you will appreciate this, that it is a virus but it appears from our preliminaries that it may be the paramyxovirus that also is part of the family of viruses that causes measles, mumps and pneumonia. We are not certain about that. I should have confirmation of that some time today. We will give that to Chairman Regula and he can distribute it to the members of the committee.

Mr. REGULA. Mr. Secretary, I think you have a lot to cover so we are going to come back to your statement when we get back. We have three votes. Let me suggest to the members, if you haven't, make an opportunity to go down and see the war room he just described to you. It will be anything beyond what you can imagine as far as an information and control center. It is terrific. Wouldn't you love those 4,000 TV stations when you were governor?

Secretary THOMPSON. I would have.

Mr. REGULA. We will recess to vote.

[Recess.]

Mr. REGULA. Mr. Secretary, we look forward to hearing more about the activities of your department. You have a lot of exciting challenges.

Secretary THOMPSON. It is exciting, Mr. Chairman.

Mr. REGULA. Yes. America depends on you.

Secretary THOMPSON. I know that and I have a great team. I think America is blessed by having some of the best doctors and researchers and scientists in the world working for the Department, NIH, CDC, FDA and HRSA. My personal staff have been wonderful and dedicated individuals. I am really blessed.

Mr. REGULA. I think you would be an inspiration to them. The captain of the ship makes a difference, a big difference. The floor is yours if you would like to add anything.

STRENGTHENING STATE AND LOCAL INFRASTRUCTURE

Secretary THOMPSON. I have a couple other things I would like to bring up. I want to thank you, Mr. Chairman, for your tremendous leadership and passion on these issues. I want to thank you for being such a good friend and advisor to me. I personally want to thank you and thank you for inviting me to be here today.

We are facing the increased risk of terrorism this week. I thought I would begin by assuring you that the department is doing a lot of things. I mentioned several already. We have also in-

creased both human and food surveillance. Being a farmer, you know how important that is because of potential biological attacks. Through the Food and Drug Administration, which I know is not in this jurisdiction, we are taking aggressive steps to increase examinations of imported food and surveillance of the domestic food industry. We have alerted State and local health departments, hospitals and health care providers to report any unusual patterns or treatment of unusual illnesses.

I would also like to make an announcement this morning. We are providing the \$1.4 billion to State governments that you and other members of Congress have appropriated to help them continue preparations against terrorism and other health emergencies. I am also happy to announce we are going to allow State governments to immediately obtain 20 percent of the 2003 grants in order to support the current preparations including the cost of smallpox vaccinations for selected health workers and emergency responders. As you know a lot of States are having severe financial trouble and we are asking them to have the smallpox vaccinations in their States and this is grant money they can use to help defray that expense. I think it will be well received at the State level. I wanted to make the announcement here at your committee because you have been so instrumental in getting this.

Of the \$1.4 billion, \$870 million is going to support the enhancement of the State public health agencies. States will use the rest of the money to help their hospitals prepare for possible bioterror or other mass casualty incidents as part of our planned Statewide response network. I want to add parenthetically the States are not drawing down the money as fast as they should. In fact, the States have only drawn down about a quarter of the money from last year and we are sending out another \$1.5 million.

Mr. REGULA. Is there a match?

Secretary THOMPSON. There is no match at all. It is just money and the money is there. They may have obligated it but is still a little disconcerting to me to tell you that they haven't done it. Even in your home State of Ohio, they have only drawn down about \$11 million of the \$30.3 million they have.

Mr. REGULA. How would the State use that money? I want to call the Governor and put a burr under his saddle.

Secretary THOMPSON. They have a plan. We asked them to develop a State health preparedness plan for communications, for getting their hospitals and laboratories more secure, being able to expand their laboratory capacity, getting their metropolitan medical assistance teams up to par, education for their emergency doctors, so on and so forth. There is just a whole plethora of issues they can spend the money for.

Mr. REGULA. Do they have to bring a plan?

Secretary THOMPSON. They have to get a plan, which they have submitted.

Mr. REGULA. They have the plans in?

Secretary THOMPSON. The plans are in. The plans were submitted as of April 15 last year. They could have obligated the money and just have not drawn down the money.

Mr. REGULA. I understand.

Secretary THOMPSON. It seems a bit strange to me. Everyone is complaining about the need for money and we have them drawing down on only an average of about 20 percent out of the \$1.1 billion. We are ready to send out another \$1.5 billion. They can use this 20 percent we are sending out now immediately for defraying costs on smallpox.

I bring this up so hopefully congressional representatives can contact their governors and say, this is some money and take advantage of it.

Mr. REGULA. Absolutely.

Secretary THOMPSON. We want them to start building the infrastructure of the State and local health departments.

Mr. REGULA. Do you think it is because they are not getting applications, that the local people don't realize this?

Secretary THOMPSON. I don't know. We keep checking. They keep saying they have obligated the money but we still have 80 percent of last year's and we are ready to send out another huge amount of money.

Mr. REGULA. Do you have that chart there?

Secretary THOMPSON. Sure.

Mr. REGULA. Let us make a copy of that for our members.

INFLUENZA PANDEMIC

Secretary THOMPSON. To summarize the area of bioterrorism, we are much better able to respond to a biological attack. We cannot prevent one but we are much better prepared to respond than I think the Congress and the vast majority of Americans believe.

As I indicated, we have constructed the state of the art command center which you have been over to see. I would like everyone to come over and see it and I make that invitation. The new tracking and plotting technology that we have also allows us to take our response activities, including our DMATS and DMORTS and the strategic national stockpile for better flexibility and better efficiencies.

We are monitoring, as you know, one situation as we speak. Right now, researchers are working to identify the cause of what has been called the Severe Acute Respiratory Syndrome. We have no reason to think the syndrome is related to influenza. The appearance of similar symptoms in scattered locations reminds us all that we should be concerned about the possibility of an influenza pandemic and how it might start.

At the request of our department, I have been very concerned about having pandemic flu outbreak. We haven't been prepared for it and we have no way to develop new vaccine to be able to stockpile new flu vaccine. We have to wait until January or February to make a determination what we think the flu is going to be that year and then we have to have the fertilized eggs in order to grow the virus. That is a very poor way because the influenza pandemic may be avian flu which could destroy the eggs which is the only way we would know how to prepare a vaccine right now which really puts us in an embarrassing situation. I want to change that and get us ready to develop a whole new flu vaccine system and have it grown out of a cell culture which is much more efficient and we could stockpile it. So the President, at the request of the depart-

ment, is asking for \$100 million to ensure the Nation has an adequate supply of influenza vaccine in the event of a pandemic.

It is in the regular bill and I think it points out this SARS thing could have been a pandemic flu and we wouldn't have been able to control it. Luckily it is not but it could be the start of something that we don't really understand in the health care field. They have all the specimens from Canada, we have specimens from Hong Kong that were flown in yesterday and they are working around the clock, Mr. Chairman, to make the analysis. I should be able to have a better and more complete picture sometime this afternoon. I will call you with that information.

Due to the constant change in the circulating influenza strains, we cannot stockpile influenza vaccine because we have to wait from one year to the next and get the eggs produced. The current manufacture methods cannot meet our Nation's need in the event of a pandemic flu. Funds will be used for activities to ensure a new year-round influenza vaccine production capacity and the development and implementation of rapidly expandable production technologies. We are going to work closely with industry to accomplish these goals.

As you may know, the influenza pandemic of 1918 killed more than 500,000 Americans in less than 10 months. We are working to make sure nothing like that happens again. We are not prepared for it. I want you to know that and that is why this \$100 million is so important.

BIOSHIELD

As you all know, last month President Bush announced Project Bioshield which is in a similar vein. We would spend roughly \$6 billion over ten years on new counter measures to prepare America for a bioterrorist attack. This proposal would speed up research and approval of vaccines and treatments and ensure a guaranteed funding source for their purchase, just the latest in our forward looking efforts to protect the homeland.

NIH BUDGET

We also recently completed doubling of the budget of the National Institutes of Health. This year we continue that commitment with a budget of \$27.9 billion, a net increase of \$718 million over last year. As a result of one-time projects being funded and accelerated in fiscal year 2003 and not needing to be refinanced, actual research contracts and investments will rise by about 7 percent to \$1.9 billion.

HEALTH CARE

Now let us turn to the rest of the budget. In my first two years, the Department has made tremendous progress in our efforts to improve the health, safety and well being of American people. We continue to make extraordinary progress in providing health care to lower income Americans. Through waiver and State plan amendments which have been granted to States, we have expanded access to health coverage for more than 2.2 million individuals. These are waivers I have granted to individuals. We have been able to get 2.2

million people covered by health insurance who didn't have it before and have expanded the range of benefits offered to an additional 6.7 million other Americans.

To build on this progress, we are proposing outlays for HHS of \$539 billion, \$539 billion for farmers, like you and me, is a lot of money, Mr. Chairman.

Mr. REGULA. Will buy a lot of hay.

HHS BUDGET

Secretary THOMPSON. Buy a lot of hay and increase a lot of cattle.

We request an increase of \$37 billion or 7 percent over last year's request, an increase of more than \$109 billion or 25 percent since 2001.

The difficulty has been the discretionary part of the budget. It increases \$1.6 billion or 2.6 percent to \$65 billion of budget authority. This was the President's proposal from fiscal year 2003 to fiscal year 2004, but subsequent to that time, the Congress has passed their budget which increased the amount of money which lowered the percentage that we had in our request. So our budget doesn't look as good when you look at that. The budget falls under the committee's jurisdiction of \$60 billion, a lesser percentage.

We are attempting to keep health care costs down and prevent chronic diseases because Americans really aren't that healthy. This is something I have talked to you about, Mr. Chairman and many members. We have to do something about it.

PREVENTION

I am really happy to talk to you about prevention. We have to encourage Americans to lead healthier lives. We have all heard the disturbing news about the prevalence of diabetes, obesity and asthma, \$155 billion a year in tobacco-related illnesses, 400,000 people die, \$132 billion on diabetes and 17 million Americans have it, 16 million have pre-diabetes conditions; \$117 billion on obesity and 300,000 people die. We are too fat, we are too sedentary and we smoke too much. We have to do something about it, ladies and gentlemen. I need your help.

I have also put my whole department on a diet. We hand out these little Walk-o-meters and you have to do 10,000 steps. If any of the members of the committee want one, I will send them up. You become somewhat addicted to them because you look at them during the day and if you haven't done close to your 10,000, you decide to walk up the steps instead of taking an elevator. It is a wonderful tool. Most of my people wear them and become very addicted. If the members of the committee would like to have one because you have been so good to us and since you have our budget, we would be more than happy to share our walk-o-meters with the committee.

Mr. REGULA. I assume you weren't sympathetic to the man on the John Deere?

Secretary THOMPSON. I don't want to go there right now, Mr. Chairman.

The HHS budget is consistent with the President's healthier efforts and proposes coordinated, departmentwide steps to a

healthier U.S. from healthier lifestyles, emphasizing prevention of obesity, diabetes, asthma, heart disease, stroke and cancer and includes an investment of \$125 million for targeted disease prevention for cities and States. I am really excited about it and I know you are too.

The President has made improvements in our Nation's health and health care one of his biggest priorities for the year. By working together, I think we can make it one of our proudest achievements. I look forward to all of the work in this committee and it is always an honor and privilege for me to come in front of this committee which I consider one of the best examples of bipartisanship at work. I think it is because of your leadership, Mr. Chairman, and I thank you for that.

Thank you for giving me this opportunity to speak twice in front of this committee. I have never had that privilege before.

YOUTH MEDIA CAMPAIGN

Mr. REGULA. Thank you. We do have a great group of members on this subcommittee. We are simply interested in helping you and in turn helping the American people.

Since you mentioned some of the programs you are doing to help people, I might start with the Youth Media Campaign. Is it working?

Secretary THOMPSON. The jury is still out but it is the VERB Program. I have to be very honest, I was one of the biggest critics of it. It was a program put out by CDC and for the tweeners, those between ages 9 and 13, to get them out of their living rooms watching television onto the playground. They have to pick a verb and act it out.

Since I am not a twener and a long ways from that and I don't have any children that are tweeners, I guess I didn't appreciate the beauty of it but as I understand from people in my office that have children in that category, they understand what the VERB is all about. We are expanding it into getting athletes to start talking about it, so I will hold my remarks and my criticisms until I see better results.

CDC tells me that this is getting very good marks, in fact much higher marks than they expected. So, I compliment them. Overall, even if it is as successful as CDC is telling me it is and was going to be even more successful in the future, I still believe we have to do more. That is why the \$125 million for healthier cities and States and healthier steps for U.S. is so important because we are too darned fat, we don't exercise and we have to get Americans out walking, running, dancing and eating properly, whatever the case may be.

HEALTHY START

Mr. REGULA. The First Lady is leading the initiative in your department known as Healthy Start, Grow Smart Program. We are pleased to initiate funding for this in fiscal year 2003. Have you started distributing these pamphlets yet? Is the program moving? I know that just got signed recently.

Secretary THOMPSON. It was signed on the 20th of February, so it is a bit early but we have the mechanism set up to get this infor-

mation out and we will continue to work on that and report back to the committee. We are making some progress.

It seemed to me, looking at the materials, we are going to give that program a greater boost.

INFORMATION TECHNOLOGY

Mr. REGULA. Have you had some success in communications? I know we talked earlier when you first got there and had I don't know how many computer systems, many of which could not talk to each other, many departments. Communications is a challenge.

Secretary THOMPSON. It was the strangest thing. We have 85,000 workstations for 63,000 people; we have 200 different computer systems; we have 3,200 individuals to maintain those 200 different computer systems; and most of the computer systems do not work together.

We are centralizing and purchasing new equipment and modernizing. We are nowhere near what I want us to be but we are making great progress. I hope to be able to report it. I want to get to the kind of computer system we set up in the command center because that is state of the art, one of the best in the country, if not the best. We should do the same for the department because our responsibility is so huge, we interact with every American and every man, woman and child on a daily basis. We have to be much more efficient than we have been in the past. We are working toward that effort. I would grade us a "B" but I want us to be an "A."

HOSPITAL TECHNOLOGY

Mr. REGULA. U.S. News recognized the value of what you are doing in the command center which I think leads to something I think is a challenge and important. That is to make the health delivery system seamless.

Secretary THOMPSON. I am so happy you raised that because that is how you are going to save money, 98,000 deaths last year because of mistakes, 50 percent because of the wrong mis-diagnoses and mistakes in doses of medicines. Just think, a floor nurse is working hard, she has the whole floor to take care of. She goes in and still have to decipher Dr. Weldon's handwriting, which is probably better than most doctors, but still not the best. Then she has to unlock the medicine cabinet, parcel out the medicine and going back, she is stopped five or six times and when she gets there, she doesn't know if it is the right time, the right dosage and whether it is going to interact with other medicines. The swipe capacity is there and that is why we are requiring the pharmaceutical companies to bar code their drugs, we just issued the rule and we are going to require all drugs to be bar coded. We want to get to the same kind of swipe capacity every grocery store has now. Grocery stores are more technologically advanced than our hospitals. They don't make mistakes. You check out, you know what it is going to be and so on. We should do that in all hospitals.

We are standardizing the rules so the technology can be interacting from one hospital to another. We are working with the Department of Veterans Affairs, which has a good control system. We want to be able to adopt that system. We are putting out dem-

onstration plans through CMS in order to get this technology done. I really think we need to have some sort of capital fund to encourage clinics and hospitals, maybe as the Chairman Regula Fund, and use dollars out of the fraud and abuse money and have it matched three to one or two to one so that hospitals and clinics put up \$3, get \$1 from the Federal Government, and be able to handle uniform technology so we could have inter-operability across America.

We would reduce costs, reduce the time and we certainly would reduce the mistakes being made in medicine. That to me is where we have to go, Mr. Chairman.

Mr. REGULA. Should we do a pilot program or should we go with it? I like it.

Secretary THOMPSON. We should deal with it. I don't know why we need pilot programs. Veterans Affairs has a very good system, certain hospitals have good systems, but nobody has put together a national system. It is there for the making. America is so technologically advanced. The technology is there, why wait? Let us put in the system, standardize the rules, bar code and maybe, as the first step, start out with the scanning capacity. That would help immensely drive the system and reduce mistakes.

Mr. REGULA. Does your budget request have some money in there to do this?

Secretary THOMPSON. No, it does not, Mr. Chairman.

Mr. REGULA. Well, then we need to put some in there. I think it is a great idea.

Secretary THOMPSON. I think it is a wonderful idea and something I have been working on but I don't have any money in there.

Mr. REGULA. Why don't you get us some information about what you think it would take as a modest amount to get this going.

Secretary THOMPSON. I think it would be fantastic.

Mr. REGULA. Because Reader's Digest not long ago had a major story on medical mistakes which you alluded to in numbers, the same thing, and we could do a great service in that respect.

I notice one of the questions we had is the fiscal year 2004 budget requests \$50 million for demonstration safety hospital information.

Secretary THOMPSON. That would be part of it but I am going beyond that. The \$50 million is a demonstration plan for hospital technology but I really think we need to incorporate the clinics, the doctors and the hospitals all together in a unified system. People say it would be very expensive and I think the dollars you would save would be much more.

Mr. REGULA. It has to start with the bar coding.

Secretary THOMPSON. Bar coding and standardization is where we start. We have to have standardized forms, standardized rules and that is what the department is working on.

Mr. REGULA. We will pursue that.

Secretary THOMPSON. I would be more than happy to give you a whole written report on it.

Mr. REGULA. I would like to have that before we do any mark up.

I have several more questions but I want to give the other members a chance. I think Ms. Roybal-Allard was the first one here.

Ms. ROYBAL-ALLARD. First of all, Mr. Secretary, let me thank you for all the hard work you did in California and with Los Angeles County to help us to get that waiver so that so many uninsured could continue to get health services.

Secretary THOMPSON. Thank you, too. It was a bipartisan effort and it was a wonderful working arrangement from Congress and the Department.

Ms. ROYBAL-ALLARD. It was a good example of how we should always be working together.

Secretary THOMPSON. Absolutely.

DISPROPORTIONATE SHARE HOSPITALS (DSH)

Ms. ROYBAL-ALLARD. As you well know, there are still some challenges facing Los Angeles County and not everything was resolved with that waiver, in particular, the disproportionate share reform proposal. It is my understanding that the State right now is in the process of finishing up that proposal. One of the things they are doing is putting in language so that existing DSH dollars can follow the patient. The reason that is so critical is because there are so many hospitals right now that are closing, so if the dollars don't follow the patient, these patients then will not be able to receive the health care they need.

I am hoping that we will be able to continue to work with you on that and that you will provide a positive response to that request.

Secretary THOMPSON. Let me just tell you that I want to work with you on it because a lot of the innovative programs that we are developing in many areas, in Medicaid, foster children, and especially for elderly programs, actually allow for the money to go with the person. I think it is the concept we should be looking at in a lot of programs nationally. I would be more than happy to work with you.

SMALLPOX IMMUNIZATION

Ms. ROYBAL-ALLARD. The new issue I would like to address may be of help to you. When I walked in you were expressing dismay as to why some of the States hadn't taken more advantage of the money available, particularly with the smallpox immunization.

Last week, the Secretary of Health of California came to my office and was very concerned about the fact that so few in California had taken advantage of it but she gave a list of reasons as to why that was so. I would like to quickly highlight some of the concerns she raised that she believed were causing serious problems in the ability for this program to move forward.

Secretary THOMPSON. Congresswoman, if I might?

Ms. ROYBAL-ALLARD. Sure.

Secretary THOMPSON. That is different than the bioterrorism \$1.1 billion. You are talking about the smallpox.

Ms. ROYBAL-ALLARD. I am talking about the smallpox, yes.

Secretary THOMPSON. That is completely different from the draw-down in the other program which is the \$1.1 billion.

Ms. ROYBAL-ALLARD. I apologize. I thought I heard you mention smallpox.

With regards to the smallpox program, she said the State has never received written verification that they can spend their Federal money on the smallpox program, that CDC has been slow to offer protocols, and that the pre-event vaccination system software is still not available, so staff is keeping notes and records on paper; that when the vaccine was made available to the States in general, they were never informed that the vaccine had a four month shelf life and therefore, in the case of Los Angeles, they ordered the full allotment which they are not going to be able to use in that four month period.

Also, Spanish language materials aren't available. There is an issue with the fact that California requires the use of safety needles but CDC and FDA have not approved one for the smallpox immunization. There has been no provision made for those who have an adverse reaction and liability questions for those administering the vaccinations have not been addressed. CDC has communicated directly with hospitals in some cases without keeping the State agency informed.

The thing I found even more alarming was that according to her the State has received no responses to its calls or its letters since January and no face to face meetings have taken place despite their request. So there are a lot of questions they can't get answered. I was wondering if you were aware of this problem and if something is being done to address it?

Secretary THOMPSON. Congresswoman, I certainly don't want to question your Secretary of Health and I would appreciate it if she would call me with these things. I just find it hard to believe because I talked to Julie Gerberding on a daily basis. We are getting more information out to every State health department. I personally had all 50 State health directors on twice in the last month talking to them about smallpox vaccinations. Nobody has raised these things to me.

With regards to the total amount of smallpox material being sent out, we sent them out with very strict instructions and I talked to Dr. Gerberding last night and said, have you heard that Los Angeles is not going to be able to utilize their smallpox in the right amount of time? She didn't know about it.

We are giving out information in both languages, Spanish and English, and we are sending out more material. You can look on our web page at CDC and get all this information you are asking about.

I don't want to argue because I want to make the program work, so if there are concerns she has, I wish she would call me or talk to Dr. Gerberding and I will be more than happy to ask somebody from CDC, more than likely Dr. Gerberding, who is just doing a wonderful job, to go out and talk to her because we want it to work.

With regards to the safety needles, the safety needles are not licensed for this product. This product was produced some in 1959, some in the late 1960s and some in the 1970s. Safety needles had not been produced then and the needles being used are the needles that were licensed with this vaccine back then and approved by FDA. FDA has not approved the safety needles, so you can't blame the CDC for something that is not licensed or licensable at this point in time.

The type of vaccine and when it was manufactured are the reasons these needles are being used and are the ones that have to be used.

Ms. ROYBAL-ALLARD. Clearly there is a breakdown in communication and I will let her know and have her call.

Secretary THOMPSON. Please. It is so important to us to get more people vaccinated in California, so please tell her to call me directly. I would be more than happy to personally take care of it. I think it would probably be more advantageous if she talks directly with Dr. Julie Gerberding. I talked to Julie at 5:30 a.m. because I heard this was going to be raised, and asked, "have you heard anything?" She said, "I have heard nothing about this."

Ms. ROYBAL-ALLARD. We need to deal with that.

Thank you very much.

Mr. REGULA. Dr. Weldon.

Dr. WELDON. Thank you, Mr. Chairman.

Mr. Secretary, I want to commend you on your depth and breadth of medical knowledge.

Secretary THOMPSON. For a lawyer, it is not bad, is it? [Laughter.]

Dr. WELDON. I continue to be amazed and certainly you would get my vote for an honorary medical degree.

Secretary THOMPSON. Thank you very much, sir. I appreciate that.

Dr. WELDON. I want to commend you for your emphasis on preventive care. I can't tell you how many death certificates I unfortunately had to fill out on people dying prematurely of a variety of conditions that were purely preventable. Certainly the President's emphasis on this and your emphasis I think is well taken. Yes, get me one of those little things for my belt and I will wear it.

Secretary THOMPSON. Thank you.

HOSPITAL TECHNOLOGY

Dr. WELDON. Regarding the medical error issue, I can't agree with you more. The bulk of the errors fortunately are not life threatening but they are related to problems in prescribing the prescription process. I believe wholeheartedly that we can utilize technologies currently not only available today but that have been available for years to develop better systems. Certainly I would love to work with you in the development of that.

Secretary THOMPSON. Thank you.

AUTISM

Dr. WELDON. I also want to commend you on your selection and the President's selection of Dr. Gerberding in the position she has at CDC. I have been working with her with the pneumonia outbreak that we are seeing, this new illness out of the Orient. I have been in communication with her and I think she is doing a superb job. I want to commend you for putting her in that position. I am looking forward to working with her and you.

One of the things I would like to work with you on is the issue of autism. I don't know if you are aware but there are about 500,000 kids with autism in the United States. We have about 1 million people with AIDS. CDC I think is spending \$10 million on

autism, \$1 billion on AIDS. NIH is spending \$2 billion on AIDS and \$75 million on autism. I am not criticizing the money going to AIDS research at all, I think that is great but we have clearly worked through the pathophysiology of AIDS, have a very good understanding of how people get it. We are essentially clueless to a large degree as to how these kids are becoming autistic and we have 500,000 of them in the United States. The costs are going to be astronomical.

Your own CDC is reporting this is a real, genuine increase in the incidence of autism. It is not a reporting change related to the DSM-4, the Diagnostic Statistical Manual. This is a real growth in numbers.

Would you be willing to work with me to try to get more funding directed towards understanding the pathophysiology of this disease so we can figure out why these kids are getting it in the first place. Particularly in light of all the additional money we have given in recent years to NIH, can't we see more funds directed towards this so that we can try to get some answers to this horrible problem our Nation is facing?

Secretary THOMPSON. Dr. Weldon and Congressman, first, let me thank you for speaking out not only on this issue but on the prevention issue as well. I want to work with you on all these issues. I especially want to work with you on autism and prevention. You know the numbers and the statistics on prevention. Seventy-five percent of the dollars are spent on chronic illnesses in America and 1.7 million Americans die of it and most of those deaths could be prevented or lives prolonged by a change in lifestyle. I and the country needs people like you that are so articulate, forceful and knowledgeable on the subject to be out there speaking on it considerably. Thank you and you will get a Walk-o-meter as well as anyone else on the committee who wants one. It doesn't look like you need it. I need it.

Dr. WELDON. Actually, ever since I got this job, I have put on about 15 pounds.

Secretary THOMPSON. Then you need two, sir. [Laughter.]

Secretary THOMPSON. Secondly, in regards to autism, there needs to be more resources put into it. I am happy to be able to report that we are going to be able to establish, I don't know if you know or not, three new autism centers. That is going to be helpful to get the information out. We are going to be able to get that started in this fiscal year. Then we will have a total of five research centers. We are going to put in three new research centers dealing with strictly autism in America.

I will be more than happy to work with you on this subject. It is something that we should be putting more resources toward and it is something that is growing. It is going to be very expensive and like you, I like to get at things before they become an epidemic. That is why I am so passionate about prevention because I can see the cost of health care just soaring in the future unless we start changing lifestyles. Automation, technology, starting prevention, getting at diseases earlier is going to be money well invested. I thank you for it.

Dr. WELDON. Mr. Chairman, I have other questions but I believe my time has expired.

Mr. REGULA. We will have another round. I think we all have others, so I hope you can stay.

Mr. Kennedy.

MEDICAID AND HEAD START

Mr. KENNEDY. Thank you, Mr. Chairman.

Welcome, Mr. Secretary.

I have a number of questions. I don't know where to start, but let me start with the overall process because I am really concerned about two things that we are embarking on that I think spell real trouble for our most vulnerable populations out there.

One is the block granting of Medicaid and one is the block granting of Head Start. How the process works affects the substances. What I am worried about is these States are all stressed with fiscal crises and if you take the Federal Head Start Program, put it into the States, it loses its national constituency. In other words, it now gets fought in the various State capitals and you know how that goes. That is a catch as catch can which means a great Federal program that has had great results now gets put into the States where it slowly disappears. This is my worry.

The same thing with Medicaid. If you have that up front bonus for holding out a couple extra dollars, the States all need the money now, they are in terrible shape. They are going to grab that money, many will grab it not only because they get extra money to help with their current budget, but also because they know with the flexibility of the block grant and the lack of entitlement which means you don't have to worry about matching it, this is a boon for the governors which is going to mean they will have the authority to set whatever standard they want.

If you have developmentally disabled children in one State and developmentally disabled children in another State, depending on whether that State's budget is doing well or the State is doing well, and depending on how progressive that State legislature is or that governor, will directly impact the quality of that mentally retarded adult and the quality of their life in various States.

If you are a poor child, single mother, on assistance needing health care, the criteria that will decide whether you get that health care will depend from State to State. Behind this, I worry about States' rights. It is a great thing. Everyone says States' rights but the last time I checked in history, States' rights meant justice depending on geography. Back in the 1960s when my uncle Robert Kennedy was fighting segregationists, the big problem was Americans would get treated differently based upon what State they came from and if they were of color, they would be treated differently in one State versus another. This is what I worry about happening to our most vulnerable people.

The quality of their health care will be determined based upon where they reside, what State they reside in and the Federal floor which protects both Head Start recipients to some extent and Medicaid recipients will disappear. It was an enormous effort to get Medicaid in the first place, an enormous effort to get Head Start. Now we are going to dilute it.

When you talk about helping the States put the money into pre-school, the fact of the matter is pre-school investment is only really

in ten States. What happens to the other 40 States? They don't show any interest in this pre-school.

Saying my State does, so you block grant the funding and I can guarantee you of the commitment my State has to Head Start. We might make a better match between that and our early pre-K but if you look at it, only five State programs have pre-K programs, lower teacher credentials in these States, 21 State pre-K.

Secretary THOMPSON. Wisconsin is one of those States. I started that program, Congressman, so that shows you where I am coming from.

Mr. KENNEDY. So you understand my concern that Wisconsin and Rhode Island are in the minority in terms of States that have pre-K programs where the teacher credentialing is halfway decent.

My question is how do we guarantee that these kids don't get packed into oversized classrooms, how do we guarantee that the teachers in front of them are credentialed, how do we guarantee that the tests that you are mandating are really tests that are evidence-based?

One of the concerns Head Start folks have is that there are over 300 experts that say the tests focus on a very narrow segment of literacy and numeracy skills. As you know, in pre-K, the real question is developmental, emotional and social. I worry if all our testing is going to the cognitive, we lose the emphasis that the current Head Start is based on and that is parental involvement and emotional and social competency.

If you can address those two macro issues, the Medicaid block granting and the Head Start block granting, I would appreciate it.

Secretary THOMPSON. I would love to. I really would like to sit down and talk to you with your staff because I am confident if you would hear where I am coming from, you would be a supporter. I may never get you to be as enthusiastic as I am but let me attempt it, Congressman, because Head Start is very important to me. As you probably know, under my leadership, Wisconsin was one of the first States to put extra State dollars into Head Start. That is where I am coming from.

Right now, the States don't have anything much to do with Head Start. Head Start is a completely separate program. I am trying to get more States to put dollars into early childhood education and development for children zero to three. That is where we really need the extra dollars.

Mr. KENNEDY. I totally agree.

Secretary THOMPSON. It is not a block grant. I know it is easy on your side of the aisle.

Mr. KENNEDY. But it does decentralize Head Start, am I correct, by giving it to the States?

Secretary THOMPSON. It is a voluntary program but it has to keep all of the existing obligations. They have to submit a plan that has to be approved by myself and Secretary Paige. It has to consist of all the protections, all the rights, that children have now. It is a way to incorporate and volunteer. It is not to in any way block grant or to allow States not to do the same things they are doing now. They have to insure that those protections will continue. That is the beauty of it. It allows for better cooperation and hopefully more State dollars to go in for early childhood which I

know that is something you want and it is something I feel passionately about.

In regards to Medicaid, it is not a block grant. I don't know if because the newspaper said it, people believe it and therefore, I am having a tough time.

Mr. KENNEDY. It has been the effort before and that is why many of us are worried.

Secretary THOMPSON. I understand. If I could quickly give you my philosophy because this is something that came out of work we did in the department.

I want Medicaid to be able to continue and to provide the services, which is evidenced by the fact that we have expanded the waiver program in the department under my leadership so that 2.2 million more Americans that were not covered before are covered and 6.7 million more Americans are getting more services because of the waiver process.

Mr. KENNEDY. We have benefitted in Rhode Island.

Secretary THOMPSON. You have.

Mr. KENNEDY. And I am for waivers.

MEDICAID REFORM

Secretary THOMPSON. In the Medicaid Program, two-thirds of the population are in the mandatory categories. The mandatory benefits are kept the same—open-ended. One-third of the population that receive Medicaid benefits is optional. It varies State by State but nationally, it is one-third. Two-thirds of services are optional, not mandatory and these two-thirds of the services make up two-thirds of the costs.

So you are dealing with one-third of the population because two-thirds of the population are mandatory. The law stays the same. One-third of the options are mandatory, they are kept the same, same rights, same rules, everything.

Now States like Rhode Island, if Rhode Island is having financial problems, can only do one of two things. They can continue to fund the program as it exists or they can stop it. In the last year because of the financial stress States are under, 38 States have dropped services to the poor, 43 States this year are going to drop coverage to at least a million because they can't have an in between. They can't require co-pays, they can't allow for a different kind of coverage. They can either keep it as it is or drop it completely.

I am giving them or hopefully the Congress will give them a third option by allowing them in Rhode Island to construct a new program.

Mr. KENNEDY. Can they do that under the waiver program?

Secretary THOMPSON. They can under the waiver program but why should they have to? I have giving the complete opportunity under our program to be able to do that and that is the beauty of it. I would love to sit down with you because it is something I think you and I should have a philosophical discussion on because I think I might even be able to convince you this is the right thing to do. I would like to be able to try.

Mr. KENNEDY. I accept the challenge.

Mr. REGULA. Mr. Cunningham.

Mr. CUNNINGHAM. Good morning, Mr. Secretary. Good afternoon, almost.

Secretary THOMPSON. Good morning, Congressman. It is always a pleasure, sir.

Mr. CUNNINGHAM. Yes, sir, working with you and Governor Engler on welfare reform, I still remember the hours that you sat there and beat us over the head and said, this is going to be terrible, they are going to yell, they are going to scream at you but it is going to be a win-win and it was thanks to you and Governor Engler. I really want to thank you for that.

Secretary THOMPSON. If I could quickly say something, I am confident that the Medicaid proposal we are advancing is going to be bigger and better and more successful than the TANF Program.

Mr. CUNNINGHAM. Chairman John Porter is the former chairman of this subcommittee. I was concerned when he left because I didn't know if anybody was strong enough to take this committee. Our current chairman has met that task and we are proud to work for him. He pushes this committee just like John Porter did and I think he is doing a good job.

During that time, I joined with John Porter to double medical research. I am a cancer survivor myself. Before I ever knew I had cancer, I supported that particular issue. We have doubled medical research and I see in the President's proposed budget there is only an increase of 3 percent. Now that we have completed the doubling of the NIH, I don't want it to depreciate because of inflation. I believe we ought to have a COLA in there that matches inflation so that we can keep that level for adequate research. Do you think this budget does that?

Secretary THOMPSON. Let me first tell you that your comments about the Chairman I endorse enthusiastically. I think he is one of the finest individuals I have had the privilege to meet since I have been here.

In regards to NIH, let me explain to you that you have the administrative, you have the capital buildings, then you have the research portion. Last year in fiscal year 2003, we had several buildings, we had to purchase \$250 million in NIH research for anthrax. We had to build new laboratories at Ft. Detrick, a BSL-4 lab at Ft. Detrick and we also have a BSL-3 or 4 lab being built on the campus at NIH. We are expanding the laboratory capacity at our laboratory in Montana.

Those dollars and then we had \$275 million sent to universities for extramural building programs which was a good thing and bioterrorism. So you add the anthrax money, the capital costs in fiscal year 2003 for our laboratories and you add back in the extramural laboratory capacity we spent on campus, and put that money back in because we don't have to respond it in fiscal year 2004, it was spent and the job was done in fiscal year 2003, so we have additional dollars going into research. The total amount of money going into research is \$1.9 billion or approximately 7 percent. We will be sending out more research grant dollars, more dollars, more research, more applications than ever before at NIH because of the one-time money being put back in and being used for research in fiscal year 2004. So the total research budget is close to 7 percent.

The only difficulty is that when Congress passed the fiscal year 2003 appropriation it took that \$250 million and said you shouldn't use it for the anthrax purchase and took it away, so we have a reduction there. We have 60 days to report back to this committee as to how we are going to make up that \$250 million. We still have about 39 days to figure that out.

DISEASE RESEARCH

Mr. CUNNINGHAM. The Chairman just told me about your facility for homeland security. I would like to see that but I also mentioned to you before when we sat down I have introduced a bill that establishes an office of Men's Health that would be a parallel program with the Women's Office of Health. It has been very successful for women. This is not a competition but there is a lot of the same cancer research, diabetes research, and just getting out the information. We lose over 44,000 men just to prostate cancer every year that we don't have to. I am a prostate cancer survivor and am living proof.

I am on the D.C. subcommittee and work closely with Mayor Williams. We had a town hall meeting on prostate cancer, because the highest incidence is with African Americans. In all the United States, the highest incidence is right here in Washington, D.C. Setting up an Office of Men's Health, I think, would go a long way to just getting out basic information.

It was Speaker Gingrich who came to us and said, if you can give people information, such as those with juvenile diabetes, on healthier living, maybe we won't have to amputate or those children won't have to go blind. It will improve the quality of life for the children and the adults, and the cost is fiscally conservative. Think of the dollars you could save. I think an Office of Men's Health, if we can get your support for it, we can pass that and I think it will enhance the Office of Women's Health. I would also like to make the Office of Women's Health permanent. Right now it is not. We would like to make it a permanent entity, not just temporary.

Secretary THOMPSON. Thank you very much. I would be more than happy to work with you, Congressman. I am very happy that you are a survivor. My wife is as well and anything we can do to defeat this insidious disease and find a cure, I am going to be there as passionate as I can possibly be and doing whatever I possibly can.

Mr. CUNNINGHAM. So for the record, you would consider supporting that?

Secretary THOMPSON. Yes, absolutely.

Mr. REGULA. Mrs. Lowey.

Mrs. LOWEY. Thank you very much, Mr. Chairman. Every day is a I love the Chairman day. I think it is relevant to all of our comments because the Chairman and I often talk about how fortunate we are to be on this committee. It makes it very difficult to prioritize our questions because there are so many issues that we all passionately care about and we are led by our great chairman.

I want to thank you for your comments. I share your concern about prevention. In fact, we are working hard in my constituency in my district to establish some fitness programs in schools with

funding from CDC and I am very excited about that. Hopefully it can be a demonstration that we can replicate in other places.

I was watching a program called PE for Life where they are doing some interesting things in Chicago and we are going to try to modify that with other suggestions from CDC and I thank you.

Secondly, I want to associate myself with the comments of Dr. Weldon. I have never seen such a great increase and there are other illnesses increasing just as fast but the parents that come to me with autistic children and they are desperate. They will run every hour to another program with their kids and list the grandfathers because they can't find it all in one school. I also would like to work with you.

Of course, fighting cancer, I am going to do it before I leave this Congress, and I can go on and on but I want to focus on homeland security and a few other items.

First of all, I do intend to go out there and I appreciate your comments.

Secretary THOMPSON. It is just down the street.

Mrs. LOWEY. I didn't know that. We will go sooner than later.

Secretary THOMPSON. It is just next door. I was in the back room and I realized that your clerk watches us every single day. [Laughter.]

Mrs. LOWEY. Good. I am glad he has his eyes on it. We are going to go down there. I appreciate that and we will do it soon.

Secretary THOMPSON. Please do. Let me know so I can be there to take you around.

HOSPITAL PREPAREDNESS

Mrs. LOWEY. Great. A couple of points. First of all, you and I agree that hospitals are key to homeland security as we prepare for what we hope will not occur. However, I am very concerned about the budget and I know it is difficult for you to respond but the budget proposes \$518 million in hospital preparedness. Just to put this number into perspective, in New York alone, hospitals have spent almost \$500 million on bioterrorism preparedness and have identified more than \$1 billion in additional needs.

My State is not alone. This morning there was a program on NPR which talked about California and the California hospitals. In each and every State, as you know, our hospitals need showers, decontamination suits, extra beds, more and better trained staff, they need isolation rooms, robust computer systems, and the ability to detect atypical disease outbreaks. Yet, because of Medicare payment reductions and the rising cost of caring for the uninsured, hospitals are already operating on shoestring budgets.

How can the hospitals be a key player in our first responder team with this kind of funding?

Secretary THOMPSON. Well, first, I think the Congress has been very generous. There was no money at all prior to 9/11 and last year we had \$1.1 billion we sent out. We currently have in our department right now \$1.5 billion, a little bit under, about \$1.44 billion to send out of which \$518 million would go for hospitals. Last year, it was \$135 million, this year it is \$518 million. Next year, we are requesting another \$518 million.

Mrs. LOWEY. Just out of curiosity, could you estimate what percent of total needs that have been submitted does that \$518 million represent?

Secretary THOMPSON. Of everything the American Hospital Association is requesting, it is probably 5 percent.

Mrs. LOWEY. I am not even talking about that. I have been meeting with my hospitals lately and I know Congresswoman DeLauro is doing the same thing, asking for their input.

Secretary THOMPSON. But there is no question that there is a lot of need out there. I also want to point out that they are not drawing down the money they currently have. We are ready to send out some more. The Mayor of New York City was in yesterday and I pointed this out. He was going to go back and find out about it. New York City has \$14 million they haven't drawn down yet.

Mrs. LOWEY. Do you know why?

Secretary THOMPSON. No, I don't know why. New York State has about \$22 million they still have to draw down. It could be, Congresswoman, that they have obligated the money because we asked them to develop a plan. They could be implementing it, so on and so forth. All I am telling you is that a good share of what New York City and New York State have coming to them has not been drawn down out of the Federal Treasury.

It could be obligated and the bills could be in the mail. I don't know, but we are ready to ship out some more dollars. We also asked them to develop a plan and the dollars we are sending out are to implement those plans on biopreparedness. Not every city, not every hospital should be a decontamination center. They should be able to plan and choose within the cities as to which hospitals are going to be critical care, which are going to be tertiary care, what is going to be for decontamination, so on and so forth. That is what we are trying to do with the planning dollars last year. I haven't looked at the plans for the City of New York, to determine whether or not they have an integrated plan but we are trying to do everything to work with them.

I think overall, Congress and the Administration have been very generous considering without any program whatsoever in this area, we are now in the second year and we are sending out this year \$1.5 billion.

STRENGTHENING PUBLIC HEALTH SYSTEM

Mrs. LOWEY. I just mention this and I see the red light is on because I think there will be and there continues to be strong bipartisan support for the military budget. A supplemental will be coming up.

In talking to my SEMO management team, even if all the money came through, he says it is barely 10 percent of what is needed in the State, and that is not just for hospitals. It is fire, police, et cetera. I think this is the opportunity to really assess what we need and get strong bipartisan support for what you feel is needed out there. If we don't do it now, I think it is going to be very difficult and I would rather be safe than sorry.

In fact, I was just in a briefing on reconstruction of Iraq and I know after the military goes in, all of our other teams are going in and I looked at what we were sending and I thought maybe we

can borrow some for some of our inner cities in New York. That is neither here nor there. I think this is the time for us to work together in a bipartisan way and be a partner in requesting the dollars that are truly needed out there.

Secretary THOMPSON. Thank you very much, Congresswoman. Let me just quickly respond in this way. For 20 years, the Congress and the States didn't invest in our local/State/public health system and it has deteriorated. Every one of us can criticize one another but all of us should accept some of the blame.

Mrs. LOWEY. I want to go back. I think you are correct. I see what we have to do now.

Secretary THOMPSON. And so we have the greatest opportunity to build something, and that is why I am really pushing my Department. I said get these plans in, but look at them because we have got to make sure that we are spending the money correctly and that we can build a strong local, State public health system that can respond not only to bio-terrorism, but infectious diseases like SARS or pandemic flu that eventually is going to come. We need to have the infrastructure in place; the hospitals, the local and State public health systems, the public responders, and all of these working together.

And I think you are absolutely correct, this is the time to build it, and I don't want to fumble the ball. I don't want to miss this great opportunity that we have together. And the beauty has been it has been done on a bipartisan basis, and I thank everybody for that.

Mrs. LOWEY. Thank you.

Thank you, Mr. Chairman.

Thank you, Mr. Secretary.

Mr. REGULA. Be sure and visit the war room down the street.

Mrs. LOWEY. We are going.

Mr. REGULA. It is fabulous, and I think it fits with what the Secretary is saying, and that is to get everybody on the same page and understanding. The health system needs to be seamless.

Secretary THOMPSON. It does.

Mr. REGULA. And that is a good start there.

Ms. DeLauro.

HEAD START

Ms. DELAURO. Thank you very much, Mr. Chairman.

And welcome, Mr. Secretary. Thank you. And I thank you for your commitment to Head Start. Let me just first say I want to associate myself with the comments of my colleague from Rhode Island. I will just make two points of this, and then I want to get to another Head Start issue.

Mr. KENNEDY. May I ask you just to yield for a second?

The Secretary talked about things that had not been published by the White House, are not on the White House website with respect to Head Start, so it would be good for us to get a clarification of some of your comments regarding Head Start, because I think it was very good to hear, as my colleague, Congresswoman DeLauro said.

Ms. DELAURO. I think two things in terms of the issue of the block granting, is that we do have national standards in place. And

I think you are of the view that we have got 85 percent of the Head Start programs or the 600 Head Start programs are meeting quality standards, why do we want to dissolve the current standards, have the States do something else; in addition to which we are going to ask States to do professional development plans, but in fact what we are not going to do is to offer additional funds to implement it.

Let me get to where I want to go on Head Start, and that is the transferring of Head Start from HHS to the Department of Education. You and I have had this conversation before, but I think it is important for the record to note, and I am going to go back to a gentleman that I believe is one of the experts in this Country, and that is Dr. Ed Ziegler at Yale, one of the founders of the Head Start program.

Head Start was created during Lyndon Johnson's war, designed to help socioeconomically disadvantaged children begin school on a par with more advantaged children. Head Start's program goal of improve physical health, enhance cognitive processes, social, emotional development; self-confidence; parental involvement; healthy family relationships; a sense of self-dignity for the child and family defined it as far more than an educational endeavor. That was the program.

I would just say to you with regard to that, if we believe that the educational component ought to be beefed up, let us do it and leave it where it is.

Also, again, this is a little historical in nature, but it is important, I think, to get this on the record.

The current proposal to transfer Head Start from Department of Health and Human Services to the Department of Education constitutes a change in orientation for Head Start; it really needs to have a very careful analysis. This should not just happen willy-nilly because someone had the idea to do this without a thorough examination.

Further, it is interesting to note, and I will go back to a Democratic administration, 1977, and I didn't know this. President Carter had made a commitment for a Department of Education during his campaign. Long and the short of it, to cut to the chase, there was a movement to move Head Start to the Department of Education. Jack Brooks in the House, Chairman of the Government Operations Committee, refused to introduce the administration's bill into the House. A Democratic chairman, Democratic administration; he refused to do that.

In the Senate interestingly enough to note, the person in charge was Abe Ribicoff, Connecticut. Okay? This is what Abe Ribicoff said to Ed Ziegler when he testified before the Committee, which was very, very interesting. And he pleaded with Senator Ribicoff, his long-time friend, to keep Head Start off of the bill that would have moved it. Ribicoff replied, "I can't help you on this one at all. I am only carrying the President's water."

Please, I am going to let that comment stand as it is for however it wants to be interpreted, but what turned the tide, what turned the tide, and this is Ribicoff, on April 27th in 1977, I was visited by a large group of mothers from Connecticut; they made this basic point. They felt the education establishment is deeply prejudiced

against Head Start. They feel their children have a special advantage by having gone through a Head Start program as opposed to their neighbors, who went right into school without Head Start.

Interesting to get their strong reactions. They felt that there were opportunities for participation in the program for them. They felt Head Start was not only an asset for their children, but for them as lower-income people who found that Head Start improved their lives and other members of their family. It was their feeling if they came into it under the educational establishment, that participation would be destroyed.

Long and the short of it, Mr. Secretary, by a vote of 14 to zero, we did not move Head Start from HHS to the Department of Education. I am not a group of mothers, but I can get them here, and I plead with you today, if we need to beef up the education component in Head Start, let us do it.

Secretary THOMPSON. Let us do it.

Mrs. LOWEY. Let us not move Head Start from where it is now to an agency that was never, it is a good agency, it was never intended to deal with the issue of Head Start. Learning is not purely cognitive. Those are not my words, but the words of the very finest educators and child development people in this country.

You know what your responsibility is; we know what our responsibility is. Please, together, let us not do this injustice to the children of this Country.

Secretary THOMPSON. I can assure you as long as Head Start is in the Department of Health and Human Services, I am going to do every darn thing I possibly can to improve it and make it better.

Ms. DELAURO. Thank you. We are not going to move it. I am going to take you at your word, and we are going to talk. We are not going to move this Department. If we have to get all of the mothers who are involved in those 600 programs, 85 percent of them, that are working to your standards, that are working right, let us not turn it around.

Secretary THOMPSON. I can assure you as long as it is in the Department, I am going to do everything I possibly can.

Ms. DELAURO. We are not going to move it.

Secretary THOMPSON. And I am going to keep working to improve it. You were not in the meetings, and all I can say is I am going to work hard to improve it.

Ms. DELAURO. Thank you.

Mr. REGULA. We have a consensus. I agree with both of you.

Mrs. Northup.

Mrs. NORTHUP. Well, I think the consensus is that young children, especially those from disadvantaged families, need a good start.

Secretary THOMPSON. They do.

Mrs. NORTHUP. And to be honest, Head Start is not always giving them that good start. Sometimes it is, but there are those Head Start programs that have resisted being educationally focused; and that is a big mistake, too. And quite honestly, I think that if people went to the wall to stop it from being moved, and that is by any chance the reason there isn't an education basis for it, then shame on them. Their vote was wrong years ago, because kids deserve to be successful in school.

They deserve to have a good start, they deserve to come in at five years old into a school, and they deserve to be prepared to be achievers. And when kids reach third grade and they are still falling behind, they begin to define themselves in other ways than how they are doing in school. Their behavior, their attention, their commitment to school all starts to slip. Now, that is what the research shows.

Excuse me, this is my time.

Ms. DELAURO. It is your time, but your information is inaccurate.

Mrs. NORTHUP. Excuse me, Mr. Chairman.

The fact is that Head Start needs to achieve at high levels too.

I have looked at so many of the things you have done; they are excellent. And I believe wherever Head Start is, and I don't really care where it is, that it can be both good for children in terms of self-esteem and social skills, and all the things that give you a chance in a holistic way, but it also can be better focused on education. And right now many of the Head Start programs, including the overwhelming complaints that I am getting from Head Start in my district, is that it is not preparing kids to be successful starting in their formal school years.

Secretary THOMPSON. Well, thank you. That is one of the reasons why the President and the Administration feels so strongly that we have got to beef up the educational portion. And that is also why I think governors should have a role to play in being able to help coordinate and help develop a better educational plan, especially for younger children.

Mrs. NORTHUP. It can do both.

Secretary THOMPSON. It can.

Mrs. NORTHUP. And part of the debate about whether it is education or health is carried on by people that have a stake in one or the other. What we need is to have a stake in both—health holistic approach and education approach. In my district, there is great resistance, great resistance by the people in Head Start to put any sort of emphasis on or be judged by or have outcomes based on the educational component. I have no belief that there is magic wherever you put it, quite honestly, but I do believe that we ought to hold these programs to a standard of educational achievement.

Secretary THOMPSON. Thank you.

PREScription DRUGS

Mrs. NORTHUP. I would like to ask you about reimportation. You know, as with a lot of things, if you want to be absolutely, positively safe, you can say no. No is the easiest answer you can ever get to. Saying yes and finding a way to facilitate to improve the chances of safety is a much harder direction to go.

You can contain costs for prescription drugs, it seems to me, in two ways: you can get out there and start regulating them, which I think has a whole host of problems associated with it, or you can create competition. And we are not going to have competition as long as the American consumer is a captive customer for the pharmaceutical companies. They are very busy at raising all the dangers, all the concerns, and they are very allied with the FDA in this. In my opinion, the Health and Human Services in both Ad-

ministrations that I have been present for have been allied with those concerns.

We must bring down the cost of pharmaceutical drugs, if there is going to be international competition, trade and international competition. And the fact is there is reimportation today. I mean, I list on my website how to safely reimport drugs. And if there is going to be this trafficking across international boundaries, we need to get busy and find ways to make it safer to protect the consumer, to allow information on where it is produced and so forth to be available to the consumer.

Secretary THOMPSON. The law that was passed said that, as Secretary, I had to attest that the drugs being reimported into the United States were the same drugs, that they were safe, and that the same amount, and they were not tampered with. It is an impossibility burden of proof on the Secretary to make that kind of affidavit.

Mrs. NORTHUP. Absolutely.

Secretary THOMPSON. So if you want to approve the drugs to be reimported it without that, that is fine, but that is not what the law said. The law says that I had to, by affidavit, say that these drugs were safe and so on and so forth. It is an impossibility.

Mrs. NORTHUP. Well, let me ask. Is there anything through Executive Order that would make reimportation easier? It seems to me like there has actually been more efforts to make the prohibition even more enforceable.

Secretary THOMPSON. Well, because the law says that. You have to change the law; that is what Congress has to do. The law says that this is illegal right now; that is why you passed the law to reimport drugs. But you also put in the caveat that the Secretary of Health and Human Services, and my predecessor said the same thing, making it an impossible task for the Secretary to make that kind of affidavit.

Mrs. NORTHUP. Well, if a law is proposed, would you support it for reimportation?

Secretary THOMPSON. I will stay neutral.

Mrs. NORTHUP. You would stay neutral, though.

Secretary THOMPSON. That is not my responsibility in the Department; I have got so many other things I have got to do.

Mrs. NORTHUP. Well, I agree it is not your responsibility, but unfortunately many of the things under your jurisdiction are impacted by the high cost of drugs, and if part of the solution is to allow international competition, then it seems to me that there would be a stake at HHS in seeing that happen.

Secretary THOMPSON. I could give you a list of things that I would like to have, as Secretary of Health and Human Services, to hold down on the cost of drugs. More than likely none of them would pass, but I can give you a lot of ideas. But the reimportation, that is something that Congress has got to make a decision about; that is really based upon safety and so on and so forth.

If you want to talk about controlling costs, we put in a proposal and that was using the basic manufacturing cost of drugs as the purchase price; and we couldn't even get a hearing on that particular thing. If you want to hold down costs, that is a giant step forward.

Mr. REGULA: Mr. Jackson.

HEALTH PROFESSIONS

Mr. JACKSON. Thank you, Mr. Chairman.

I want to start by thanking Secretary Thompson for being here today and for his testimony.

Mr. Secretary, I am extremely disappointed that for the second straight year the President's budget eliminates virtually all funding for HRSA's, health professions training and diversity programs. The Minority Centers of Excellence, Health Career Opportunities and Scholarships for Disadvantaged Students programs play a critical role in supporting both the minority health profession students and institutions.

As you know, Congress provided an increase for these accounts in the recently passed fiscal year 2003 appropriations bills. How can the Administration claim that it is championing historically black colleges and universities while eliminating funding for programs that provide core support to our Nation's historically black health professions schools?

Secretary THOMPSON. Congressman, you asked this question last year, and I understand your passion for it and I applaud you for it. Let me tell you that we looked at it in the Administration that we are trying to do a job to get individuals, minorities as well as people that need the help, and to get the services out into the communities. That is why we are putting more money into the National Health Service Corps—an additional \$42,000,000 into that. And it is 4300 individuals that we got into hard-pressed areas, into minority areas and inner city areas; and we think that is a better use of the money.

And I want to point out that we get most of these additional dollars, which is \$218,000,000 go to three African-American colleges: Morehouse, the one in Nashville, and Howard. And that is where we get a good share of our individuals.

We get 100 percent of the minorities that sign up for this program are individuals ready to graduate from college to go out, and this is money that goes directly to these three colleges and to help us pay back the loans and to be able to help recruit individuals to go into hard-pressed areas. We only get about 30 percent of the HRSA program of individuals going into hard-pressed and areas that need doctors; and that is why we think it is a better utilization of the dollars.

Now, you and I could differ on that, but that is the rationale. And we also want to put more money into community health centers; and that is why we figure community health centers and the National Health Service Corps are better investments, HRSA health professionals program. And when you have to make a choice, that is the decision. So that is the rationale.

And in regards to whether or not we are doing enough in this area, you know, we can debate that, but I really think there is a logic and a rationale for why we are doing it.

Mr. JACKSON. I have a couple of other questions, Mr. Chairman. But I do want to respond to that very briefly, Mr. Secretary.

Secretary THOMPSON. Sure.

HEALTH DISPARITIES

Mr. JACKSON. This Committee, long before you became Secretary, set out on a path to close health disparities in the country.

Secretary THOMPSON. Right.

Mr. JACKSON. We followed a and demanded that the Institute of Medicine do a detailed report on health disparities in the nation, and they released a substantial report called "Unequal Treatment." Part of that report led your good offices to partner with Tom Joyner and a number of others.

Secretary THOMPSON. I led that effort, as you probably know.

Mr. JACKSON. Part of the partnership to take your loved one to a doctor.

Secretary THOMPSON. Tom Joyner and I joined up on that; it was Tom Joyner's idea and I enthusiastically joined him.

Mr. JACKSON. Exactly. But the Institute of Medicine report, which this Committee has been following up on to close some of these profound gaps, has put specific emphasis on health professions, the need to provide the resources to close these profound gaps not only in the African-American community, but Hispanic community and other minority communities; and that the likelihood that doctors trained in those environments, or health professionals trained in those environments, would end up back in those communities was greater if in fact this Committee made that investment.

And so while we will beg to differ on the approach, I want it to be clear that this isn't a shot in the dark just based upon last year; the Committee has been specifically following the recommendations offered by the Institute of Medicine in a very detailed and comprehensive report titled "Unequal Treatment."

Secretary THOMPSON. Claude Allen, who is my deputy secretary, one of his primary responsibilities is to equalize the services. We want to do a much better job and we are putting a lot of initiatives in this area, Congressman.

Mr. REGULA. Mr. Jackson, would you yield a minute?

Mr. JACKSON. I would be happy to.

Mr. REGULA. I want to just tell the Committee members this topic is so important that we are dealing with today that I plan to have another day of hearing. So if you are waiting for another round, we are happy to have you stay, but if you have additional questions that you want to get.

And I assume you would be willing to come back. Would you?

Secretary THOMPSON. I would love to come back.

Mr. REGULA. But I can tell from the line of questioning there is just a lot of important topics here, and I would like another day, because I have questions myself.

Secretary THOMPSON. And I would like to talk about AIDS.

Mr. REGULA. Okay.

AIDS

Mr. JACKSON. That is fine. AIDS is actually my next question.

But, Mr. Chairman, reclaiming my time, I would be more than willing to have another day of questioning on health professions

and the cuts. I assume that that is the additional day that you want to have, on my subject?

Mr. REGULA. Well, some of it.

Mr. JACKSON. Thank you.

Mr. REGULA. About five minutes worth.

Mr. JACKSON. Thank you, sir.

Mr. Secretary, similar to many States around the Country, Illinois is facing a severe shortage in its Medicaid budget that could affect reimbursements and/or access to medications for people living with HIV and AIDS. Cuts in State low-income programs mean that more people will seek life-saving treatment for HIV and AIDS through Care Act programs. If Ryan White Care Act programs other than AIDS drug assistance programs are cut or flat-funded, States may be put in the difficult position of choosing between funding HIV/AIDS treatment programs and being prepared for other public health needs.

Given almost no increase in the Ryan White Care Act funding, how can Illinois and other States be expected to address the growing HIV/AIDS epidemic while also maintaining a solid public health infrastructure?

Secretary THOMPSON. The problem we have, Congressman, is that we submitted a budget. And, when we don't have Congress pass the appropriation bills until after we submitted our budget, and you increase the funding, it makes us look like we are not as supportive. And I want to tell you that we proposed an increase in the Ryan White; we put the increase, much more so than even Congress did, in the ADAP program, which goes to the States and supports drug therapy treatments.

And so we introduced our budget on February 5th. The President signed the fiscal year 2003 appropriation, which makes us look like we are level funding and cutting back, when we actually have put in a nice increase from fiscal year 2003 to 2004.

Mr. JACKSON. Would you support a higher number?

Secretary THOMPSON. What?

Mr. JACKSON. Would you support a higher number?

Secretary THOMPSON. Congressman, I will support whatever passes out of this Committee.

Mr. JACKSON. Mr. Chairman, I have one final question, if I might.

Mr. REGULA. Okay.

MINORITY AIDS REPORT

Mr. JACKSON. I am sorry, I have one final question, if I might, Mr. Chairman.

In fiscal year 2003 conference report, the Committee requested a comprehensive report detailing the implementation of the minority AIDS initiative. I am eager to see the report. As we go into fiscal year 2004, people of color continue to make up over 70 percent of the new HIV infections, and 2001 made up more than 70 percent of AIDS cases diagnosed that year.

As the crisis among these communities continue to grow, what at your Department do you suggest that these communities do?

Thank you, Mr. Chairman.

Secretary THOMPSON. We have to do more. The report that you are talking about, is due October 15, 2003 and we are working on it.

We have to do more in the Ryan White program; we have to provide more information; we have to do more in prevention. And as you know by the President's State of the Union speech, he is absolutely committed to fight this fight internationally and with a huge increase of new dollars, \$10,000,000,000. I am now Chairman of the Global AIDS Fund. So you can see by our actions that we are dedicated to fight this fight domestically and internationally.

And I want to work with you. I mean, I certainly don't have all the answers. If you can assist me in coming up with solutions, and how we can do a better job in the minority community, I will be more than happy to listen to them and work with you.

Mr. JACKSON. What I think I can do, Mr. Secretary, is I think I can assist you in coming up with a number so that I can go to the chairman and make the case for the kind of funding that we need to do this together.

Secretary THOMPSON. Okay.

Mr. JACKSON. Thank you, Mr. Secretary. I am grateful.

Secretary THOMPSON. Thank you, Congressman.

Mr. REGULA. Okay, for those that are still here, we will take one minute for each of you, if you would like to get something that you still want to get in.

Mr. Kennedy, you wanted a minute?

Mr. KENNEDY. Speaking about waivers, Mr. Secretary.

Secretary THOMPSON. Yes.

MEDICAID RIDE PAY

Mr. KENNEDY. We have got one pending in front of your HHS for our program, which allows our seniors to buy prescription drugs through our RIPAE program; expand the eligibility under the Medicaid RIPAE.

Secretary THOMPSON. Is it budget-neutral?

Mr. KENNEDY. It is budget-neutral.

Secretary THOMPSON. When was it submitted?

Mr. KENNEDY. Several months ago. I will get you the information.

Secretary THOMPSON. Okay, fine.

DISPROPORTIONATE SHARE HOSPITALS (DSH)

Mr. KENNEDY. And then, you know, we had our fire up in Rhode Island. It has taken an enormous toll on our hospitals because most of it is uncompensated care. And I was wondering what your comments were on what you think you can do to help with our DHS payments and maybe one-short deal.

Secretary THOMPSON. Somebody told me that you were going to ask me that today, and I haven't had a chance to review it, Congressman. I will be more than happy to look at it. Whether or not the DSH payments can be used for it, I am sure it can be, but may require some additional waiver. Let us take a look at it. I want to be helpful. As you know, we sent several of my people up to assist the governor.

Mr. KENNEDY. Yes. And we thank you for that. They did a terrific job.

Secretary THOMPSON. I think they did do a good job. The governor called me and met me.

Mr. KENNEDY. Yes.

Secretary THOMPSON. So we want to be helpful. It is a serious, serious problem.

MENTAL HEALTH

Mr. KENNEDY. Finally, the mental health response on terrorism. We talked a lot about bio-terrorism, but if a crisis breaks out, as we had of the anthrax, all our hospitals get clogged with people with psychosomatic, thinking that they have got something. And I am wondering what the Department is doing with Homeland Security to address the panic factor in any potential attack.

Secretary THOMPSON. We have SAMSHA developing plans on that; it is being worked on. I certainly wouldn't say that it is the best, but we are working on it.

Mr. REGULA. Mrs. Northup a minute.

Mrs. NORTHUP. Yes. I would just like to speak up on the mental health issue too.

You know, we spend a lot of money on Medicaid and SAMSHA and State grants on mental health mental retardation centers. Mental health is where an enormous amount of the money goes. But, unfortunately, they have not created, in most cases, a seamless system. There is hospitalization or jail time, of course, if they are picked up by the legal system. For those that are the most ill, homeless shelters.

But our mental health centers are not creating a seamless system. In Louisville \$60,000,000 comes into that system, and it mostly serves those that are the least ill or the least sick. They provide minimal services to the homeless, to the community health systems, and so forth.

By not creating the seamless system, they also make sure that there is not a system available to the private insurance—to the whole rest of the system. I mean, if the public dollars are not creating the basis or the foundation of the need, then they can't be combined with private dollars to help create a seamless system for everybody.

I know the President has created a task force across Cabinet lines to address mental health issues, and I ask you to do all you can to help. You control the majority of those dollars, and they overlap with HUD and the Justice Department. But it is an enormous failing, and when you consider the amount of dollars that are spent out of Medicaid for the billing for Medicaid, out of SAMSHA, out of block grants, it is really amazing that we don't have a better system.

Secretary THOMPSON. I would appreciate your suggestion, because the Department is tasked by the President to lead this inter-cabinet agency task force.

Mrs. NORTHUP. Well, I have one right off the bat, and that is that we say that mental health centers that are charged with the planning can't also be the deliverer of the services. Because what they do is fling out a few dollars to homeless centers, a few dollars

to the community health, and then they absorb the rest internally by, in a sense, cherry-picking, the easy-to-serve. They serve the people that actually show up at 1:00 every Wednesday, instead of those that you have to outreach, and collaborate with on the street.

Secretary THOMPSON. You know the President has put \$600,000,000 in over three years, \$200,000,000 each year, for a new voucher program that I think certainly can accomplish a lot of your things, and Congress is going to have to help us develop that program. But it is something the President feels very strongly about.

Mr. REGULA. Mrs. Lowey.

Mrs. LOWEY. Thank you, Mr. Chairman. One minute or four minutes?

Mr. REGULA. You can have a couple.

CANCER RESEARCH

Mrs. LOWEY. Thank you very much. I will talk very quickly.

I share your passion for finding a cure for cancer, and I have been working very hard with my colleagues in particular on breast cancer, and we have been talking for a long time about the need for women over age 40 to have an annual mammogram, and I felt for a long time that it is time we really begin pushing hard to find a new generation of early detection. And I would be interested to know in the couple of minutes, you probably can't respond, but if you have, I would be interested to know what HHS has really done to advance this cause and what more we can do.

Secretary THOMPSON. Well, it is one of my real passions because my mother-in-law died from breast cancer, my wife is a survivor of breast cancer, and I have two daughters, and it is time for us to find a cure. I don't know if it is better right now to put the resources into early detection or in finding the cure. I think we need to find the cure; and that is where I think we should put the resources. But I think you are right, I think waiting until 40 years old to find out is not the way to go.

Mrs. LOWEY. And I also think, and I know there is some work being done on determining through early detection whether it is a passive cancer, whether it is an aggressive cancer, should they treat it. There is work being done having to do with MRIs, specific new machines, and I would be interested to know if we can have a dialogue on what HHS is doing.

Secretary THOMPSON. Absolutely.

DEPARTMENTAL WEBSITE

Mrs. LOWEY. And then I will save it for the next session, but I have been concerned what appears to me to be highly, shall we call them, political ideological decisions coming out of HHS, and I would like to talk to you about it. For example, Henry R. Hyde and I have been concerned, and we have had a bill on covering prenatal care. Suddenly it turned to care for the unborn. I would be interested at some point how it turned from prenatal care to care for the unborn.

Secondly, there was information on the website concerning connections between abortion and cancer, breast cancer.

Secretary THOMPSON. No, that has been changed.

Mrs. LOWEY. Yes, but I am interested, because it created tremendous anxiety. I know you are redesigning the website, but how did it get there in the first place? Was this based on NCI science or was it based on someone that may not have been routed in science putting it on the website? And I think this is really of great concern to many of us, so if you can answer those questions quickly.

Secretary THOMPSON. I wish you would talk to Andy vonEschenbach because the National Cancer Institute on the website was under his control. I asked him about it; he told me that they wanted to do a scientific study, get this settled once and for all. The scientific study was done and it showed that there was not a correlation between abortion and breast cancer.

Mrs. LOWEY. Do you think it was irresponsible to put it on the website before the scientific study was done?

Secretary THOMPSON. They took everything off until the scientific study was done, and I think that caused some people some angst, but I think it is over and done with now, and we will never have to have that particular problem again.

In regards to prenatal care, that one you can blame me because that is mine. I made that decision because, you know, I believe very strongly that a child coming into this world should have the best care possible, and it is prenatal care. It is not abortion, it is not pro-choice, pro-life; it is prenatal care.

Mrs. LOWEY. So why didn't you call it prenatal care?

Secretary THOMPSON. That is what I did call it.

Mrs. LOWEY. No, you called it care for the unborn child.

Secretary THOMPSON. Well, it is prenatal care for me, and that is what it was all about. The same woman, if she was in Medicaid, she would be able to get prenatal care; but a woman with SCHIP would not.

Now, you and I both want the healthiest child to come into this world. That is what I want and that is why I did it.

Mrs. LOWEY. I would just like to say, and I would appreciate the opportunity to have a longer discussion.

Secretary THOMPSON. Why don't you call me up?

Mrs. LOWEY. Let us do it.

Secretary THOMPSON. Come on over and see my command center or have lunch with me.

Mrs. LOWEY. Let us do it.

Secretary THOMPSON. All right.

Mrs. LOWEY. And just in concluding, as you know, I think we have to be careful as public officials, you as the Secretary. Some of these phrases, words connote other things.

Secretary THOMPSON. I know.

Mrs. LOWEY. And if Henry Hyde and I can work very closely on potential funding for prenatal care, we could call it prenatal care rather than the care for the unborn child. And at some point we can talk at our lunch why the information on sex education and condoms came off the website too. To be continued.

Mr. REGULA. I want to caution you.

Secretary THOMPSON. I think you and I need a long lunch.

Mrs. LOWEY. I think so. It would be a pleasure.

Mr. REGULA. Well, I want to caution you, it will be a low calorie lunch.

Mrs. LOWEY. You notice I didn't, when I was talking about fitness, I didn't say how many pounds I have gained.

Secretary THOMPSON. Yes, but did you want one of our Walk-o-meters?

Mrs. LOWEY. Absolutely. I would love one.

Secretary THOMPSON. Will you use it?

Mrs. LOWEY. Absolutely.

Secretary THOMPSON. Every day, now, you have got to walk 10,000 steps.

Mr. REGULA. Ms. DeLauro.

Ms. DELAURO. Thank you.

I just want to take a moment, not to interrupt anyone else's time, but I think that when we do talk about programs like Head Start and we do talk about accountability and any of the problems that we talk about, we ought to be dealing with accuracy and with facts, because I don't think inaccuracy serves anyone's purpose, and particularly doesn't serve well the children who are involved in the programs.

I think just, again, for the record, I think it is important to note, and I think that these are the standards that you have in place, Mr. Secretary, that Congress has put in place national standards for Head Start and evaluations from the Department of Health and Human Services. You say that it is working. You reported from the monitoring of nearly 600 Head Start programs 85 percent of the programs are meeting quality standards. I will introduce, I will put into the record, so that I don't have to say them all here, the basis for that; how children are leaving their program ready to learn.

Can it be better? We know that. But I will not stand by and listen to inaccuracy on a program that has served this Country and the children of this Country very, very well. Let us be precise.

I also said if the education portion has to be beefed up, we need to take a look at that.

Secretary THOMPSON. You said that.

Ms. DELAURO. And let us do it and leave the powers as it is.

Secretary THOMPSON. And I agree with you.

Ms. DELAURO. I too have questions on mental health and what is happening in our schools. I will submit that one for the record.

Ms. DELAURO. Just two very quick things. On the WISEWOMAN program, Congressman Leach and I have a bill to expand that to the 50 States. Can we count on your support for this kind of legislation? The WISEWOMAN program has been absolutely successful in what it does. Your help shouldn't be determined by your geography.

Secretary THOMPSON. Yes.

Ms. DELAURO. Thank you.

And if you can't answer this now, if you can get this to me. How much would it take to fully fund the WISEWOMAN program so that all States will benefit? If you can just get me that piece of information.

[The information follows:]

WISEWOMAN

Secretary THOMPSON. The WISEWOMAN demonstration program offers cardiovascular screening and counseling services to uninsured and underinsured women

aged 40–64 who qualify for other services through the National Breast and Cervical Cancer Early Detection Program. The program is currently authorized to be carried out in only three States, with funding directed through the National Breast and Cervical Cancer Early Detection program. Recent appropriations bills have overridden the authorization to allow these demonstrations in more States. The FY 2004 budget contains \$10 million for 12 States and tribal groups. Set up as a demonstration, WISEWOMAN was never intended to provide services to all low-income women ages 40–64. But rather to evaluate the effectiveness of providing this set of services to this population. CDC estimates that the actual amount it would cost to fully fund WISEWOMAN in all States would be \$185 million. The breakdown for their estimate is as follows: \$147 million to state-based programs (average award of \$2.1 million); \$5 million to national organizations; \$8.7 million for prevention research; \$3 million for public and provider education; \$5.3 million for evaluation and \$16.5 million for program oversight and technical assistance. The FY 2004 budget focuses on expanding cancer screening and does not propose to expand the WISEWOMAN demonstration. It should be noted that HHS has made increased access to health care, including screening, for the uninsured a high priority through a range of programs including those in CMS and HRSA's Health Center program. The Health Center program is requested at \$1.6 billion in FY 2004, +\$122 million over FY 2003.

Ms. DELAURO. Final point is about newborn screening. And I note your State has, you know, one of the finest screening programs in the Country, but my understanding is that there are no new dollars for newborn screening. That troubles me, that there isn't any money to fund the Title XXVI grants. Am I wrong in that effort? And if that is the case, why can't we get any money for newborn screening?

Secretary THOMPSON. I will get you the answer.

Ms. DELAURO. Okay, please. Thank you very, very much, Mr. Secretary.

Secretary THOMPSON. Thank you. It is always a pleasure. Congressman, thank you.

Mr. REGULA. Thank you, Mr. Secretary. I think, as you can see, we have had a thought-provoking hearing.

Secretary THOMPSON. It has been a very good hearing.

Mr. REGULA. And we would like you to come back. This topic is to important to the people of America; I mean, health and family, that is where it is.

Secretary THOMPSON. That is where the action is.

Mr. REGULA. It really is. And thank you for coming and your patience this morning. We will see you at the next one.

[The following questions were submitted to be answered for the record.]

NEWBORN HEARING SCREENING

Secretary Thompson: While we are not requesting specific funds for the Universal Newborn Hearing Screening program in HRSA, the Department continues to be committed to strengthening the Nation's newborn screening system.

The Maternal and Child Health Block Grant, which we increased by \$21 million in FY 2004, for a total of \$751 million, provides States the flexibility to fund services like newborn hearing screening. Through the Maternal and Child Health Block Grant's Special Projects of Regional and National Significance, funding will continue to be provided to States to enhance their capacity to better integrate their newborn screening programs with the State Title V community-based system of services for Children with Special Health Care Needs. Federal dollars through Medicaid, which reimburses for newborn screening services for eligible infants, provides another funding option that States can utilize for the over one-third of all births that are Medicaid eligible. Technical assistance, screening technology training and educational resources will also be available through the MCHB-funded National Newborn Screening and Genetics Resource Center to support States in their newborn screening efforts.

On February 3, 2003, I approved the establishment of the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children as a first step in implementing Title XXVI of the Children's Health Act of 2000. Specifically authorized by the Act, the Committee will provide advice and consultations to me on matters related to grants and projects authorized by the Act and the development of policies and priorities that will reduce mortality or morbidity from heritable disorders.

SUBSTANCE ABUSE TREATMENT

Mr. Regula: In his State of the Union the President announced his substance abuse treatment voucher initiative, Recovery Now, and the budget request for this new initiative is \$200 million. Please tell us how this program will work. How will someone who needs this treatment receive a voucher? And then walk us through the program from there.

Secretary Thompson: Individuals in need of treatment and who seek it will be directed by a school counselor, physician, social worker, minister, or friend to a State designated contact who will arrange an assessment by a trained professional who is not affiliated with any particular treatment facility. The person conducting the assessment will make recommendations with regard to the extent and level of treatment needed. At this point States have flexibility in designing the process. The assessor or another person designated by the State may give the individual a voucher for the level of care the individual needs and provide a list of potential providers. From this list the individual will choose a provider and present themselves along with the voucher to the facility. The voucher itself will have no monetary value.

Mr. Regula: What kinds of services are covered through this program? Will this program cover supportive services such as childcare or transit? What about family support services for children or spouses of drug and alcohol abusers?

Secretary Thompson: A variety of treatment or support services could be covered by a voucher. The individual in need of services will go through an extensive assessment that will include recommendations for treatment. The professional that the State chooses to carry out an assessment will make determinations on the level of care. An individual may need support services to help them maintain a stable life free from drugs and alcohol. A voucher could be given for this level of care along with a list of potential service providers. The professional may also determine that family services are needed and the voucher would cover these services. For example, if the individual needing treatment is a pregnant addict or a woman with children, an appropriate facility might be one that permits the children to be with the mother. As another example, an individual who is part of an outpatient program may need transportation funds to get back and forth to the program. Such supportive services will only be provided as a necessary component of treatment. States will indicate how services they intend to fund through the initiative are necessary to achieve positive treatment outcomes. States will also commit to cost ranges and reimbursement levels by treatment modality, which will include supportive services.

Mr. Regula: Why is such a large investment in treatment needed right now?

Secretary Thompson: Data from the National Household Survey on Drug Abuse estimates that nearly 6.1 million individuals in the United States are in need of treatment. Seventy-six percent of these people are individuals who do not recognize that

they need treatment. Some 17 percent or 1.1 million received treatment at some point during the year at a specialty facility. Some 5 percent recognized that they needed treatment, but for some reason did not seek treatment. Finally there are 2 percent, or roughly 101,000 individuals, who recognized that they needed treatment, sought treatment, but were unable to receive treatment. These individuals deserve our immediate help. At the same time, our efforts will hopefully encourage the 276,000, or 5 percent, who recognized that they needed treatment but did not seek the treatment needed to move toward recovery.

This investment is an important component in stemming the enormous cost that substance abuse has on society. A report entitled *The Economic Cost of Alcohol and Drug Abuse in the United States*, funded by National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, estimated the total cost of alcohol and drug abuse to society at \$276 billion. These costs to society include lost productivity, medical services, treatment costs, and the costs of incarceration related to drug-related crimes.

Mr. Regula: Is the incidence of drug and alcohol abuse on the rise?

Secretary Thompson: I am pleased to report that genuine progress has been made in reducing the incidence of drug and alcohol abuse by youth. Particularly encouraging have been the most recent results of the school-based *Monitoring the Future* survey, which often serves as a harbinger of our future as a nation with respect to drug use. Drug use among young people, for the first time in several years, is going down in many areas, signaling what we sincerely hope will be a process of recovery for the nation.

While we are encouraged by this reduction in drug and alcohol use by young people, there continues to be a great need to expand our nation's drug treatment capacity. Five percent of individuals in the United States recognized that they needed treatment but for some reason did not seek treatment. Of this total, 2 percent, or roughly 101,000 individuals, recognized that they needed treatment, sought treatment, but were unable to receive treatment. Another 276,000 individuals, or 5 percent, recognized that they needed treatment but did not seek the treatment needed to move toward recovery.

Mr. Regula: Why do we need a program like this when there is already a Substance Abuse Block Grant to States?

Secretary Thompson: The President's Drug Treatment Initiative is a multi-program approach. We continue to support and maintain State substance abuse treatment systems through our Substance Abuse Block Grant. In FY 2004, the President is requesting \$1.8 billion, a \$31 million increase, for the Block Grant. Our Targeted Capacity Expansion Program will continue to help us identify and address new and emerging trends.

Now, through Access to Recovery, the President has given us a third mechanism to increase treatment options. Access to Recovery is an innovative approach, which is client-based, not provider-based, and has a more direct and immediate emphasis on outcomes. This initiative promotes individual choice and would allow an individual to use Federal substance abuse dollars to choose effective treatment organizations, including faith-based organizations. The voucher program will provide consumer choice and focus on treatment outcomes in ways that are not currently available through either the Block Grant or the Targeted Capacity Expansion grants.

Mr. Regula: How do you foresee the population living in rural and other underserved communities taking part in the voucher program?

Secretary Thompson: People in rural areas typically do not have a choice of provider. We are hopeful that the voucher program will entice providers to create satellite programs in rural areas to provide services. A State may still be able to use Block Grant funds or State funds to increase services in rural areas. Thus States would be able to leverage funding to increase treatment capacity in rural areas.

Mr. Regula: Will the Administration be seeking authorization for this program? If not, under what authority will this program operate?

Secretary Thompson: Sections 501 and 509 of the Public Health Service Act provide the authority needed to make competitive grants to States to operate voucher programs.

FAITH-BASED SERVICES

Mr. Regula: Increases have been requested in programs with a focus on faith- and community-based participation, Mentoring Children of Prisoners and Compassion Capital Fund, among others. Have you had good responses from faith-based community programs in applying for grants?

Secretary Thompson: The public has shown a tremendous interest in the Compassion Capital Fund (CCF) program. We had 367 applications for CCF demonstration program in 2002; the program's first year, yet, we could only make demonstration grant awards to 21 intermediary organizations. The organizations funded in FY 2002 are charged to assist faith-based and community organizations by providing technical assistance, helping them improve organizational efficiency and program effectiveness, and assisting the organizations in expanding and diversifying their funding base. Because of the work of the intermediary organizations, and considerable interest in the first year the program was funded, we expect the interest and number of applications for grants under the Compassion Capital Fund to continue to grow.

While the Request for Proposal (RFP) for Mentoring Children of Prisoners has not been finalized, we anticipate having an excellent response from community and faith-based organizations due to the great interest voiced since Congress appropriated funds.

Mr. Regula: Can you give us examples of the types of activities faith-based groups are providing in their communities?

Secretary Thompson: Examples of the types of existing mentoring activities include:

- In a large metropolitan city, 50 inner city congregations have recruited 500 volunteers to mentor children of prisoners.
- In a south-western city a coalition of community service providers have come together to provide "wrap-around" services to prisoners who are re-entering the community.
- In a large mid-western city a local mentoring program has partnered with a large corporation to recruit mentors and the corporation found an increase in the productivity of the workers who participated.

An example of a current Compassion Capital Fund grantee:

- Father Joe's Villages, part of St. Vincent De Paul Management, Inc. based in San Diego, CA, is a nationally renowned model for the provision of comprehensive and integrated social services to the homeless. Father Joe's project will offer training and sub-awards to faith-based and community organizations, will assist in building collaborations and networks of organizations, and will disseminate best practices in the area of homelessness services.

FULL TIME EQUIVALENT

Mr. Regula: Provide a chart showing by OPDIV the number of FTE the budget assumes will be reassigned (transfers, retirements, resignations) by the end of FY04 as a result of OMB Circular A-76 analysis.

Secretary Thompson: The chart showing by OPDIV the number of FTE the budget assumes will be reassigned (transfers, retirements, resignations) by the end of FY04 as a result of OMB Circular A-76 analysis follows:

OPDIV	CS-FTE
AoA	0
ACF	(-13)
AHRQ	0
CDC	0
CMS	0
FDA	(-43)
HRSA	0
IHS	0
NIH	0
OS	0
PSC	0
SAMHSA	(-12)

All HHS OPDIV's subject to competitive sourcing developed their appropriate competition plans for FY 2003 and FY 2004. Three OPDIV's (ACF, FDA, and SAMHSA) assumed changes to their FTE counts, due to competitive sourcing, within their respective FY 2004 budgets. The remaining OPDIV's did not project FTE reassignments through the end of FY 2004 resulting from Circular A-76 analysis.

Mr Regula: Provide a chart showing by OPDIV the number of full-time [equivalent] positions projected to be on board at the beginning and end of FY03 and FY04.

Secretary Thompson: The following table shows actual FTE levels for FY 2002 and budgeted levels for FY 2003 and FY 2004.

HHS FTE FY 2002-2004

	FY 2002 Actual	FY 2003 Budget Target	FY 2004 Budget Request
FDA	9,528	10,479	10,841
HRSA	1,844	1,937	1,912
IHS	14,899	14,961	15,021
CDC	8,663	8,668	8,671
NIH	17,250	17,693	17,526
SAMHSA	582	588	572
AHRQ	278	294	294
CMS	4,497	4,661	4,586
ACF	1,465	1,512	1,472
AoA	120	120	120
OIG	1,569	1,640	1,559
OCR	246	268	268
DM	1,414	1,536	1,532
PSC	1,151	1,151	1,151
Total HHS FTE	63,506	65,508	65,525

Mr. Regula: Provide a chart identifying by OPDIV the reductions taken in information technology funding in the FY04 budget request as a result of the OMB passback and the FY02 and FY03 bases on which those reductions were taken.

Secretary Thompson: Below is a chart identifying by OPDIV the reductions taken in information technology funding in the FY04 budget request.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Discretionary Information Technology FY 2002 - FY 2004 /1 (Dollars in Millions)							
Table 1	FY 2002	FY 2003	FY 2004	FY 03-FY 04 Change	FY 03-FY 04 % Change	FY 02-FY 04 Change	FY 02-FY 04 % Change
OPDIV							
FDA	175.804	188.525	161.857	-26.668	-14.1%	-13.947	-7.9%
HRSA	27.662	27.819	26.111	-1.708	-6.1%	-1.551	-5.6%
IHS	53.278	55.096	39.388	-15.708	-28.5%	-13.890	-26.1%
CDC	169.479	174.113	150.240	-23.873	-13.7%	-19.239	-11.4%
NIH	575.367	637.476	523.465	-114.011	-17.9%	-51.902	-9.0%
SAMHSA	34.609	35.554	25.756	-9.798	-27.6%	-8.853	-25.6%
AHRQ	33.249	33.122	34.575	1.453	4.4%	1.326	4.0%
CMS	395.505	353.001	395.896	42.895	12.2%	0.391	0.1%
ACF	15.634	7.759	15.477	7.718	99.5%	-0.157	-1.0%
AOA	2.979	2.283	1.943	-0.340	-14.9%	-1.036	-34.8%
OS	16.505	12.657	10.442	-2.215	-17.5%	-6.063	-36.7%
OIG	1.999	2.401	2.357	-0.044	-1.8%	0.359	17.9%
PSC	72.841	88.240	69.250	-18.990	-21.5%	-3.591	-4.9%
Sub-Total	1,574.911	1,618.046	1,456.757	-161.289	-10.0%	-118.153	-7.5%
Enterprise & E-Gov Initiatives (see Table 2)	52.920	94.940	135.335	40.395	42.5%	82.415	155.7%
Total	1,627.831	1,712.986	1,592.092	-120.894	-7.1%	-35.738	-2.2%

/1 Excludes Grants, Mandatory, User Fees and Interagency Agreements

Table 2 HHS Enterprise & E-Gov Initiatives

HHS Enterprise Initiatives and HHS Participation In Government-Wide E-Gov Initiatives Are Funded With OPDIV Contributions And The GDM IT Security & Innovation Fund			
OPDIV	FY 2002	FY 2003	FY 2004
FDA	9.290	17.670	TBD
HRSA	0.752	3.038	TBD
IHS	1.722	3.091	TBD
CDC	11.119	20.504	TBD
NIH	2.981	13.505	TBD
SAMHSA	0.542	0.667	TBD
AHRQ	0.151	1.443	TBD
CMS	2.470	11.172	TBD
ACF	0.350	1.385	TBD
AoA	0.025	0.518	TBD
OS	23.370	21.015	TBD
OIG	0.148	0.932	TBD
Total	52.920	94.940	135.335

Mr. Regula: What are the principal activities and authorities of the HHS Facilities Management office under the Assistant Secretary for Administration and Management? How many FTE are assigned to the office?

Secretary Thompson: The Office for Facilities Management and Policy (OFMP), in the Office of the Assistant Secretary for Administration and Management, is responsible for the following:

- Departmental policy development and interpretation for planning, design, construction, operations and maintenance, leasing, building management, environmental management, historic preservation, physical security of space occupied by HHS employees, and Occupational Safety and Health Act (OSHA) implementation;
- plans, oversees and directs Department-wide facilities planning, design, programming and construction;
- oversees Operating Division (OPDIV) operations and maintenance of HHS facilities; property management of leased facilities; land and space management; disposal and transfer of HHS real property; environmental management; facilities energy management; historic preservation; physical security of space occupied by HHS employees; and OSHA reporting;

- development of and administrative and operations support to the Department's Non-IT Capital Investment Review Board;
- oversight responsibilities for OPDIV facilities master plans that call for the acquisition and construction of numerous state-of-the-art laboratories, research centers, office buildings and other support facilities; and
- delegated (GSA) authority for the operations and maintenance of the Hubert H. Humphrey Building (HHS HQ facility)

OFMP current staffing:

- 1 Deputy Assistant Secretary
- 11 personnel reassigned from within ASAM who operate, maintain, and manage space in the Humphrey Building
- 3 personnel plus one detailee to coordinate Departmental policy issues in the areas of environmental management, energy management, historic preservation, physical security and OSHA reporting
- 6 personnel temporarily detailed from other HHS components (CDC, FDA, IHS, NIH and OS) with specialized skills needed to perform the OFMP activities:
 - Departmental Construction Oversight: 1 Detailee
 - Departmental Capital Planning: 1 Detailee
 - Departmental Operations and Maintenance Oversight: 1 Detailee
 - Departmental Building Management Oversight: 1 Detailee
 - Departmental Leasing Oversight: 1 Detailee
 - Administrative: 1 Detailee

Mr. Regula: What is the status of the human resources staffing reorganization? Where will the four human resources sites be located and which OPDIV will each [provide] service? Which entity is managing the Rockville human resources operation?

Secretary Thompson: The consolidation of human resources offices at HHS continues on schedule. The four servicing centers – located in Bethesda, Baltimore, Atlanta and Rockville – will begin operations on October 1, 2003. In preparation for beginning operations, the implementation team has developed the structure and staffing levels for the four centers, along with a process for identifying staff to move to the new organizations.

The Bethesda center will provide service for the National Institutes of Health; the Baltimore site will provide service to the Centers for Medicare & Medicaid Services and the Indian Health Service; the Atlanta center will service the Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry; and the Rockville site will provide service for the Agency for Healthcare Research and Quality, the Administration on Aging, the Administration for Children and Families, the Health Resources and Services Administration, the Food and Drug Administration, the Substance Abuse and Mental Health Services Administration, the Program Support Center, and the Office of the Secretary. The four servicing centers report to the Deputy Assistant Secretary for Human Resources.

Mr. Regula: Provide a chart showing the number of end of year personnel positions for human resources activities in FY02-FY04 by OPDIV.

Secretary Thompson: The following table portrays end-of-year HR staffing in HHS for FY 2002. The four centers will begin operations in FY 2004 with 941 staff – a ratio of 1:75. This number will decline in FY 2004 to reach a ratio of 1:82, or 860 staff. In the consolidated model, all four centers will be administratively part of the Program Support Center, with no human resources staff in the Operating Divisions.

Placing the four centers in the Program Support Center allows HHS to fund them on a fee-for-service basis through the Department's Service and Supply Fund (SSF). This in turn provides greater accountability to customers, since the Centers' budgets are reviewed and approved on annual basis by the SSF Board of Governors, which is made up of representatives from the Operating Divisions. The Center directors will report, however, to the Deputy Assistant Secretary for Human Resources, not the Deputy Assistant Secretary for Program Services. While this reporting line is at odds with organizational structure, it is in full accord with program management direction, unifying human resources management responsibility across HHS.

With the four centers beginning operations on October 1, it is impossible to accurately forecast human resources staff in the Operating Divisions on September 30, the end of fiscal year 2003. HHS plans to manage reductions during the remainder of the fiscal year, maintaining service but positioning staff for the consolidation. The Department will use early retirement authority and voluntary separation incentives if approved by the Office of Personnel Management to manage staff size. Operating Divisions will also be looking to place and re-deploy human resources staff. These unknowns make it impossible to forecast human resources staffing accurately by Operating Division at the end of fiscal year 2003.

HHS Human Resources Staffing by Operating Division (FY 2002)	
OPDIV	FY 2002
CMS	135
HRSA	48
CDC	175
FDA	188
IHS	227
NIH	365
PSC	113
Total	1,251

Mr. Regula: Provide a chart identifying the number of approved SES slots by OPDIV in 1999 and 2003.

Secretary Thompson: The following table shows career SES positions in the Department of Health and Human Services at the beginning of fiscal years 1999 and 2003.

Career SES Positions in HHS Fiscal Years 1999 and 2003		
OPDIV	FY 1999	FY 2003
OS	61	65
AoA	2	2
CMS (HCFA)	38	37
ACF	11	9
HRSA	15	17
CDC / ATSDR	23	25
FDA	63	50
IHS	14	16
SAMHSA	11	10
NIH	171	115
AHRQ	3	3

Mr. Regula: What is the current and proposed end of year FY04 servicing ratio of human resources employees to total staff?

Secretary Thompson: HHS presently has one human resources staff member to 56 staff (1:56). At the end of FY 2004, HHS's human resources servicing ratio will be 1:82, a level we feel is attainable based on achieving economies of scale and efficiencies of operation through consolidation.

Mr. Regula: What benchmarks have been established to judge customer service as experienced by OPDIVs as the human resources consolidation proceeds?

Secretary Thompson: HHS is developing and documenting baseline data on current levels of human resource services to provide a basis for comparing current human resources services with those that will be provided after consolidation. The benchmarks center on broad measures, including:

- Cost for human resources services;
- Servicing ratio;
- Timeliness of key services (such as classifying jobs and filling positions),
- Customer satisfaction (as measured by a survey of managers).

In the past, HHS has not had standard metrics for human resources services that were comparable across the Department, due to the differences in service delivery models, staffing patterns, servicing ratios, and populations serviced. However, the cross-cutting metrics that have not existed in the past provide the very data that HHS will need to measure the success of the consolidated centers. We believe that this effort is a key part of the overall consolidation, and we expect to have substantive benchmarks of current services completed in the late spring before we begin the staffing of the new centers.

Mr. Regula: Have incentives and penalties been built into the human resources system to recognize the findings of such benchmarks?

Secretary Thompson: HHS has carefully considered how to make the consolidated HR sites accountable to their customers. The benchmarks being developed will provide a basis for determining the success of the consolidated centers. The consolidation has taken three additional important steps to assure the centers are accountable to customers and to measure the success of consolidation.

First, we have actively engaged the Operating Divisions in the selection of the center directors. Teams of OPDIV managers conducted the interviews for the center director positions and recommended the top two candidates for each job. By engaging the OPDIVs at this stage we have made the selection a joint process and ensured that neither the Department nor the OPDIVs are solely responsible for filling the jobs. This joint selection process assures that the center directors are acceptable to both Department-level management and to OPDIV customers.

Second, we have designed the center functions to specifically include senior account managers. These account managers will work with the OPDIVs to develop specific service agreements, spelling out services to be provided as well as standards for timeliness and quality. After service agreements are developed, the account managers will monitor success in meeting the standards and work with managers to resolve problems.

Finally, we have closed the loop on accountability by including customer OPDIVs in the process of appraising the center directors' performance. Customer satisfaction – with input from the customers – is a key part of the center directors' appraisals. This means that customer service and meeting service standards are more than paper exercises, but are key parts of accountability to customers.

LAPSE OF FUNDING

Mr. Regula: Which program within the G/D/M account was responsible for the \$2.2 million lapse of funding in FY02?

Secretary Thompson: The following table shows the accounts within the General Departmental Management (GDM) appropriation with the largest amounts of lapsed funding in FY 2002, as shown in the official accounting records as of October 2002. However, since that time payments have been made on a number of bills which came in for amounts larger than originally estimated, and several large posting errors have been corrected; the result is that the current FY 2002 lapsed amount for GDM is now less. The \$2.2 million is a lapse of 0.64 percent in an overall appropriation of \$346.1 million.

GENERAL DEPARTMENTAL MANAGEMENT
FY 2002 LAPSED FUNDS
as of October 2002

STAFFDIV	LAPSE
Departmental Appeals Board	\$368,136
Asst Secy for Budget, Technology & Finance	331,227
Asst Secy for Administration & Management	265,606
Office of Emergency Preparedness (OEP)	262,609
Overhead/ Service & Supply Fund Payments	252,702
Office of Public Health & Science (except OEP)	205,030
Immediate Office of the Secretary	163,194
Office of the General Counsel	123,021
All other GDM	<u>255,113</u>
Total	\$2,226,638

FAITH-BASED AND COMMUNITY INITIATIVES

Mrs. Northup: I am happy to see that the Department has focused support on programs that link faith- and community-based organizations, State and local governments, and Federal partners. Numerous faith-based programs in my district have shown considerable success in their ability to reach out and meet the needs of the people of Louisville every day. From counseling the troubled to feeding the hungry and caring for the disabled, I have been impressed with their commitment and capacity to serve. These creative organizations operate on less than significant amounts of money with great success. What process does the Department of Health and Human Services utilize in assessing the suitability of faith-based partners for government support?

Secretary Thompson: Unfortunately, in the past faith-based groups were not given fair access, because of their affiliation. One of the goals of this Administration is to level the playing field by removing barriers to the full participation of faith-based and community organizations so that they have an equal opportunity to participate in federally funded programs. The HHS Center for Faith Based and Community Initiatives has been fully integrated into the Department, working with the Administration for Children and Families, Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration, among others to coordinate a comprehensive effort to incorporate faith- and community organizations; identify barriers to the participation of faith- and community organizations; and to coordinate outreach to disseminate information more effectively to faith- and community organizations.

HHS is committed to ensuring that faith-based organizations are treated no differently than other organizations eligible for federal funding from this Department. All proposed grantees, whether or not they are faith-based, are expected to meet the terms and conditions of the award. This includes any special award conditions which may be imposed to protect the Government's interests and effect positive change in a grantee's performance or compliance, including the quality of their management system. All applications are initially ranked based on scores prepared by independent reviewers. After the award is made, grants management and program staff work with applicants to ensure that approved applications adhere to administrative, programmatic, and technical requirements.

Mrs. Northup: Can you elaborate on the types of programs and funding available for such organizations under the current budget?

Secretary Thompson: Faith-based and community organizations are eligible to receive and administer a wide range of "Federal financial assistance" – assistance provided to non-Federal entities for which nonprofits are eligible. This includes grants, contracts, loans, loan guarantees, property, cooperative agreements, food commodities, direct appropriations, or other assistance, whether they are administered by the Federal Government, or by a State or local government.

While there are some programs within HHS' budget request that focus on faith-based and community groups it is important to emphasize that HHS administers a wide range of social service programs that can be administered by faith-based and community organizations including: child care services, protective services for children and adults, services for children and adults in foster care, adoption services, services related to the management and maintenance of the home, day care services for adults, and services to meet the special needs of children, older individuals, and individuals with disabilities (including physical, mental, or emotional disabilities), services directed at reducing poverty, improving opportunities for low-income children, revitalizing low-income communities, empowering low-income families and low-income individuals to become self-sufficient, or otherwise helping people in need, health support service, literacy and mentoring programs, services for the prevention and treatment of juvenile delinquency and substance abuse, services for the prevention of crime and the provision of assistance to the victims and the families of criminal offenders, and services related to intervention in, and prevention of, domestic violence. The goal of the initiative is to ensure that faith-based and community groups have full access to programs and funding sources that they have been unfairly denied access to in the past.

There are a number of specific programs I would highlight within the current budget request: Head Start and the new Mentoring Children of Prisoners program administered by the Administration for Children and Families (ACF); Substance Abuse Treatment and HIV/AIDS programs managed by the Substance Abuse and Mental Health Services Administration (SAMHSA); as well as Healthy Start and Transitioning Healthy Child Care America programs administered by the Health Resources and Services Administration (HRSA), among many other opportunities.

It is HHS' goal to ensure that faith-based and community organizations receive appropriate guidance regarding requirements that apply to federal funds that they may receive. In December of 2002, SAMHSA and ACF published proposed charitable choice provisions for several of their programs. The comment period has closed, and the agencies are currently analyzing comments in preparation for drafting final regulations. The proposed rules would ensure that religious organizations are treated equally with others when applying for HHS funds, and would also protect them from having to make changes affecting their religious character when using those funds. They would also make clear that organizations must serve all individuals who are eligible for HHS services equally, regardless of their religious affiliation or beliefs. Further, the proposed regulations clarify that federal funds may not be used to pay for religious activities. The proposed rules also provide for referrals to alternative providers if an individual objects to an organization's religious character.

HHS has undertaken several programs of special interest to faith-based and community organizations. In September of 2002, HHS awarded \$30 million in grants from the Compassion Capital Fund. Among other things, funding from the Compassion Capital Fund supports twenty-one intermediary organizations that will provide technical assistance to help faith-based and community organizations effectively access funding

sources, operate and manage their programs, and develop and train staff. The FY 2004 President's Budget continues a commitment to support faith-based and community organizations, requesting a total of \$100 million for the Compassion Capital Fund. The 2004 Budget also requests \$50 million for the Mentoring Children of Prisoners program. Through support for these organizations positive outcomes can be achieved.

HOMELESSNESS

Mrs. Northup: Over the past several years, I have been concerned that the organizations meeting the needs of the hardest to serve populations are receiving minimal Federal funding, while other service providers are receiving larger amounts to serve "easier" populations. One of the harder-to-serve populations that I am particularly concerned about is the homeless, a group that I believe to be continually overlooked in the distribution of Federal funding. Mental health centers in my home district of Louisville alone receive \$66 million annually from Medicaid, State grant and other Federal funding sources. Out of that figure, approximately \$6 million is devoted to contracts serving the most difficult cases. Do you believe that mental health service providers, particularly community mental health centers, are adequately targeting resources to individuals with the most severe mental illnesses?

Secretary Thompson: There are many competing demands on the scarce resources available for mental health services. Each State determines its expenditures based on advice and assistance from many sources. The SAMHSA Mental Health Services Block Grant program, which represents an average of only 1 to 3 percent of a State's total expenditure on mental health services, requires that each State develop a plan on how all of their resources will be utilized. Because the remaining funds are provided by Medicaid, Medicare, State and local revenues, and other Federal and non-Federal sources, the targeting of mental health resources is a continuing issue. However, we are seeing some progress in influencing the targeting of State expenditures. Funds from the Mental Health Block Grant can only be used in providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance. These are often the hardest to serve. We also anticipate that the upcoming final report from the President's New Freedom Commission on Mental Health will guide us in responding to these and other critical mental health needs.

Mrs. Northup: How can we ensure cooperation among mental health service providers in delivering a seamless support system for these hard-to-serve populations?

Secretary Thompson: HHS/SAMHSA has been working to address the issue of cooperation among mental health service providers through our systems coordination and integration efforts to ensure that there is "No Wrong Door" to services. For example, in FY 2003, HHS, HUD and the VA in a collaborative effort, have issued a

joint grant announcement aimed at providing housing and health, mental health, and substance abuse services in a seamless support system for the homeless. We do recognize that we still have a long way to go.

We expect that, when it is available, the final report from the President's New Freedom Commission on Mental Health will guide us in responding to these and other critical mental health needs. The Commission acknowledges the fragmentation of services that exists within the current system of care and we expect to be fully responsive to their recommendations.

SAMARITAN INITIATIVE

Mrs. Northup: Following up on the homeless issue and its application to Health and Human Services, I have had numerous conversations with officials from the Interagency Homelessness Council regarding the integration of housing and support services for this population. I understand that the Bush Administration has undertaken HHS/VA-HUD "Policy Academics" to educate States on the vast array of services that are available to homeless individual in their States and to encourage cooperation between sometimes disparate agencies. Continuing in its commitment to end chronic homelessness within a decade, the Administration has also implemented a new Samaritan Initiative. This initiative, supporting the most promising strategies to move the homeless off the streets, includes a new comprehensive competitive grant to be jointly administered by HUD, HHS and VA. Have any specific efforts been devoted to planning for this Samaritan Initiative by the Department of Health and Human Services?

Secretary Thompson: HHS and HUD staff have been working together for the last two years to improve the provision of services to chronically homeless persons. Examples of this collaboration include: listing and defining the health and social services needed by chronically homeless people, developing the agendas for State Policy Academies on chronically homeless people and homeless families with children, and establishing the Joint Chronic Homelessness Initiative which provides housing, health and social services, and veterans services through a joint grant application. These collaborations have laid the foundation for HHS to participate with HUD in the development of the Samaritan Initiative.

Mrs. Northup: What do you see as the primary obstacles to effective collaboration between government agencies with overlapping service populations?

Secretary Thompson: The Joint Chronic Homelessness Initiative, which is a HUD, HHS and VA initiative, demonstrates that agencies can collaborate on projects which serve overlapping populations. It also points out some of the difficulties that may be encountered. Most notably, variations among the authorizing statutes of government programs can make effective collaboration between government agencies a challenge. Such variation can include who is eligible to receive services, which specific services can be provided, which types of organizations can receive funds to provide these

services and how these organizations apply and account for the funds they receive. For example, under the Joint Chronic Homelessness Initiative, funds for services for homeless veterans can only be provided through the VA hospitals and clinics. HUD is seeking new authorizing legislation for the Samaritan Initiative to address some of these differences.

NURSING SHORTAGE

Mrs. Northup: According to a study released by the Southern Regional Educational Board (SREB) in February 2002, a serious shortage of nursing faculty was documented. The survey found that unfilled faculty positions, resignations, projected retirements and the shortage of graduate students being prepared for the faculty role pose a threat to the nursing education workforce over the next five years. The nursing shortage remains a tremendous concern across the nation. In 2002, Congress passed and President Bush signed the Nurse Reinvestment Act into law and, in FY 2003, Congress provided start up funding of \$20 million for programs to retain nurses, provide scholarships to nursing students, focus on practice areas of highest need such as geriatrics, and attract nurses into the faculty role. Could you update us on the implementation of these programs? Will they will be operational in FY 2003?

Secretary Thompson: The signing of the Nurse Reinvestment Act marked a significant step forward in America's commitment to ensuring that our health care system remains the best in the world. This year, we will begin implementing the new scholarship portion of the loan repayment and scholarship program, the new retention portions of the nurse education, practice, and retention grants program, the new nurse faculty loan program, and the new comprehensive geriatric education program.

Under the scholarship program, nursing students will receive financial assistance for educational costs in return for at least two years of service at a health care facility with a critical shortage of nurses. The revised loan repayment provision of this program also requires service obligations to be fulfilled at health care facilities with critical nursing shortages. New efforts to retain nurses will include internship and residency programs to ease the transition from the classroom to the workplace. The faculty loan program will allow nursing schools to award educational loans to individuals seeking advanced training to become nursing faculty. Finally, a new broad-based geriatric education program will be implemented to enhance training to address the rapidly growing need for elderly care. These programs will be implemented and operational in FY 2003. We anticipate making application materials available in April and May and funding them by the end of the fiscal year.

NATIONAL SAMPLE SURVEY OF REGISTERED NURSES

Mrs. Northup: In this time of nursing shortage the availability of timely workforce data is essential. Last year, you unveiled the National Sample Survey of Registered Nurses. This is the seventh survey that has been conducted and is the

nation's most extensive and comprehensive source of statistics on all those currently licensed to practice in the United States, whether or not they are employed in Nursing. This survey was conducted in the year 2000. This data is critical to focusing Federal efforts on the nursing workforce which is key to our public health, homeland security, and national defense. Are plans underway for the next survey on the nursing workforce? When will the process begin and what can be done to assure timely release of the data?

Secretary Thompson: We are currently on schedule to begin our eighth National Sample Survey of Registered Nurses. This survey, which is conducted every four years, is scheduled to begin collecting data in March of 2004.

At this time we are in the process of obtaining OMB clearance to conduct the survey while simultaneously awarding a contract to perform the work. We do not foresee any problems that might affect timely release of the survey's findings.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS REGULATIONS

Mr. Cunningham: Mr. Secretary, there are companies in my district who manufacture diagnostic tests. These companies have expressed concerns to me regarding regulations recently published by the Centers for Medicare & Medicaid Services (CMS) with respect to the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Specifically, they are concerned that CMS intends to implement these new regulations on April 24th without having ready inspection/compliance guidelines (Surveyor Guidelines) to accompany the new rule. There is ambiguity in the rule itself about which approaches to quality control will be CLIA compliant, and CMS has sent conflicting signals about whether the agency's draft new guidelines will be published and available by March 31st, and therefore whether laboratory directors will have the guidance they need prior to the effective date of the regulation. In light of these concerns, Mr. Secretary, could you please provide some clarification: When will CMS publish the draft Surveyor Guidelines for the new CLIA standards?

Secretary Thompson: The "draft" Surveyor Guidelines have been released for review and feedback to experts in the laboratory community, manufacturers, professional organizations, and State and Regional CLIA consultants. Once this feedback has been received and evaluated, we anticipate a fall-publication date for the guidelines. The guidelines will also appear on our CLIA web site.

Mr. Cunningham: Does CMS intend for these Guidelines to allow laboratories furnishing nonwaived tests with "internal" or "built-in" quality control mechanisms to satisfy quality control requirements under the new rule by following manufacturer's instructions with respect to these items?

Secretary Thompson: The use of "internal" or "built-in" controls is dependent on whether these controls meet or exceed the requirements now at 42 CFR Part 493.1256(d)(3). In the event they meet or exceed the new requirements, the laboratories must follow manufacturer's instructions. A laboratory's decision to use test systems with "internal" or "built-in" controls is contingent upon the quality system the laboratory uses to ensure and improve the accuracy of testing and whether these controls monitor the precision and accuracy of the complete analytical process.

HEAD START PROGRAM

Mr. Obey: Secretary Thompson, the Administration has indicated that it is considering transferring Head Start from the Department of Health and Human Services to the Department of Education. However, it has not forwarded this proposal to the Congress. Furthermore, the Administration has requested funding for Head Start in the budget request for the Administration for Children and Families in HHS. Can you please tell me if the President has made a decision on this issue, and, if so, when we should expect to receive the appropriate notification?

Secretary Thompson: The President's FY 2004 budget proposes to move Head Start to the Department of Education effective FY 2005. FY 2004 is proposed as a transition year where the program will continue to be administered by the Department of Health and Human Services while preparations are made to assure an orderly transfer to the Department of Education.

Mr. Obey: The Administration's budget also states that it will propose legislation to reauthorize the appropriate sections of the Head Start Act. However, the only information we have seen is the "Policy Paper" on the White House Website. What is the status of the reauthorization proposal? Has the Department of Health and Human Services participated in drafting the reauthorizing legislation? Other than reading the White House Website, when should the Congress expect to receive the legislative proposal?

Secretary Thompson: The single most important goal of the Head Start reauthorization should be to improve Head Start and other preschool programs to ensure children are prepared to succeed in school. The Administration's *Head Start Policy Book* presents a framework to improve school readiness by allowing interested States to integrate State and federal preschool programs including Head Start into a cohesive system. The Administration is working with the authorizing committees to translate the framework into legislation as part of Head Start reauthorization.

Mr. Obey: Head Start is acknowledged as a highly successful program in helping prepare young children for school. On February 24, 2003, you sent a letter to Congressman Boehner in which you stated that HHS' annual monitoring of Head Start grantees had found that 85% of the grantees reviewed had provided quality services, with the remaining 15% requiring some corrective actions. I am pleased to hear you acknowledge the effectiveness of the Head Start; however, I am puzzled to hear that the Administration is contemplating major changes to the program. Is the Administration planning to change the fundamental mission of the Head Start program which has focused on all aspects of child development? If so, why?

Secretary Thompson: To strengthen the Head Start program, improve services to low-income children, and promote the coordination and integration of comprehensive early care and education services, the Administration is asking Congress to include in

the reauthorization of the Head Start Act a provision that will allow interested States to include Head Start in their preschool plans.

Under this proposal, States will be offered the opportunity to better coordinate preschool programs with Head Start programs in exchange for meeting certain accountability requirements. States wishing to participate must submit a plan for approval that addresses several fundamental issues concerning preschool education.

The State plan must address how it will work with the public school system to develop goals for all preschool programs in the State; identify guidelines that preschool programs can use to achieve these goals; devise an accountability system to determine whether children are achieving the goals; provide professional development for preschool teachers and administrators; and, help parents provide support for children to succeed in kindergarten. In addition, States must describe how they will maintain the comprehensive range of child development services for children in Head Start, including the provision of social, parental, and health services.

Mr. Obey: I am also hearing that, as part of the Head Start restructuring, the Administration is planning to change it to a formula grant program to States which many of the advocacy groups think is a prelude to dismantling Head Start. You yourself have acknowledged the effectiveness of the Head Start program and the existing grantees, which makes it all the more troublesome to hear that the Administration is considering making this a formula grant to the States. Please clarify the Administration's intentions for me. Does the Administration plan to make the Head Start program a formula grant program?

Secretary Thompson: No, the Administration is not proposing to make Head Start a formula grant program. Under the Administration's proposal, States will be offered the opportunity to better coordinate preschool programs with Head Start programs in exchange for meeting certain accountability requirements. States wishing to participate must submit a plan for approval that addresses several fundamental issues concerning preschool education as described above.

Mr Obey: What role, if any, do you foresee for the current Head Start grantees? Does this Administration see a role for the Head Start community which has contributed to the success of this program?

Secretary Thompson: The single most important goal of the Head Start reauthorization should be to improve Head Start and other preschool programs to ensure children are prepared to succeed in school. The Administration's proposal will give States the flexibility to integrate preschool programs with Head Start programs for the State or a region within the State. This approach allows States to draw on the strengths of existing Head Start programs while fostering comprehensive, high quality preschool programs. In States that don't elect this option, Head Start will continue to be managed as a Federal-to-local program.

Mr. Obey: What is the Administration's objective in making the Head Start program a formula grant program to the States?

Secretary Thompson: The Administration is not proposing to make Head Start a formula grant program. Under the Administration's proposal, States will be offered the opportunity to better coordinate preschool programs with Head Start programs in exchange for meeting certain accountability requirements. States wishing to participate must submit a state plan for approval. Head Start will continue to be managed as a Federal-to-local program, except in those instances where States have an approved State plan for comprehensive and integrated preschool services.

Mr. Obey: Is this an attempt to help bail out States, which are currently experiencing financial difficulties?

Secretary Thompson: Any State choosing to develop a plan for comprehensive and integrated preschool services that is approved must continue to serve as many Head Start eligible three- and four-year olds as are currently being served through Head Start and they must provide the comprehensive services currently found in Head Start, including social, family, and human services. In addition, States must maintain their current level of State spending on preschool programs. Therefore, States will not be able to cut back on state preschool spending because they now have Head Start dollars.

Mr. Obey: Given the financial situation in many of our States and the heavy burden imposed by the requirements of the "No Child Left Behind Act," the prospect of taking funding from successful Head Start grantees and giving it to States which have had little interest in pre-kindergarten programs is troublesome. How can we ensure that the States will continue the same level and quality of services currently provided by the Head Start program?

Secretary Thompson: The Administration's purpose in making this option available to States is to allow States to improve coordination of preschool programs and Head Start programs to better meet the needs of children. States will receive Head Start dollars only when they have an approved plan in place that supports this goal. Any State that takes advantage of this option will be expected to make a commitment to maintain the integrity of the comprehensive nature of Head Start services, including social, family, and health services. At the same time, States must improve the educational components of Head Start.

Mr. Obey: The Head Start program has placed a special emphasis on teacher quality, particularly on improving teacher credentials. What will happen to Head Start quality initiatives under the Administration's proposal?

Secretary Thompson: Under the Administration's proposal, States will be offered the opportunity to better coordinate preschool programs with Head Start programs in exchange for meeting certain accountability requirements. States choosing

to participate must submit a State plan. One of the requirements for the State plan is to ensure the ongoing professional development of staff and administrators.

Mr. Obey: Does the Administration plan to establish similar quality standards for State programs, especially those regarding teacher credentials?

Secretary Thompson: Under the Administration's proposal, States will be offered the opportunity to better coordinate preschool programs with Head Start programs in exchange for meeting certain accountability requirements. States choosing to participate must submit a State plan for approval. One of the requirements for the State plan is to ensure the ongoing professional development of staff and administrators. Both the Secretary of Health and Human Services and the Secretary of Education must approve the state plan before a State can receive Head Start dollars.

Mr. Obey: In the FY 2004 budget, President Bush has proposed a \$150.8 million cut to the Community Services Block Grant program from \$646 million in FY 2003 to \$495 million in FY 2004, a 23% cut. The Administration has stated that this reduction is based on the lack of strong performance data for this program. Please describe the process for developing performance measures.

Secretary Thompson: The Administration is working collaboratively with State Community Services Block Grant (CSBG) authorities and local eligible entities to identify approximately 10 to 12 national performance indicators for the CSBG program. Most of the outcome measures being considered are those for which data are now being collected from a majority of States and eligible entities through "Results Oriented Management and Accountability," or ROMA. ROMA has been a bottom-up, mostly voluntary, process over the past nine years to install performance-based systems among States and local agencies receiving CSBG funding. By making these outcome measures mandatory, as part of the CSBG reauthorization, more consistent data can be collected and an analysis of effectiveness can be conducted for each grantee.

Mr. Obey: Does the Department have standards or guidelines for performance measures? Whose responsibility is it to establish the performance measures? Is it the responsibility of the States which receive the grants and make grant awards? Or is it the responsibility of the individual grantees?

Secretary Thompson: From its inception, ROMA has been premised on collaboration among the Federal, State and local entities that comprise the Community Services Block Grant (CSBG) Community Services Network. The Administration for Children and Families (ACF) has used training and technical assistance to underwrite the development of voluntary national goals to focus the work of agencies receiving CSBG funding, model tools for measuring family, community, and agency outcomes, and provide training of State and local program officials on how to utilize outcome-focused management principles to redesign and strengthen service delivery strategies, family and community outcomes. As indicated, ACF is already engaged in a

collaborative process with States and local eligible entities to identify those outcome measures to be included in the statutory revisions proposed by the Administration as part of the CSBG reauthorization. These measures will be applied consistently to all CSBG grantees.

Mr. Obey: What kind of technical assistance does the Department provide to the States and/or to the grantees?

Secretary Thompson: The Administration for Children and Families (ACF) has underwritten several national training, and information-sharing resources focused on implementing CSBG-funded programs in a manner that is consistent with the statute's antipoverty mission, and that encourages performance-based programs at the State and local levels. Funds have supported a national academy to train veteran and new State and local community action executives in performance-based management concepts; a national ROMA clearinghouse; and several other executive leadership programs that promote creative, outcome-focused approaches to community action management.

COMPASSION CAPITAL FUND

Mr. Obey: The President's budget includes a request for \$100 million for the Compassion Capital Fund, an increase of \$65.2 million over the FY 2003 appropriated level. This would nearly triple the funding for this initiative. It is a substantial increase by any standard; however, it is an extraordinary increase for a relatively new initiative. What is the status of the funding appropriated for this initiative since it was begun the first year of this Administration? Have you obligated the funding? When and to whom were these funds obligated?

Secretary Thompson: The Compassion Capital Fund was established in the second year of this Administration (FY 2002). Funds appropriated in FY 2002 have been obligated in four areas:

- \$24,773,117 for the Compassion Capital Fund Demonstration Program (21 grantees).
- \$858,809 for Compassion Capital Fund "Research and Studies Related to Social Services Provided by Faith-Based and Community-Based Organizations" (4 grantees).
- Approximately \$2 million for a contract to establish a National Resource Center for faith-based and community organizations and to provide technical assistance to the Compassion Capital Fund intermediary grantees.
- \$1,350,000 for a contract to examine services and best practices of intermediary organizations and the faith-based and community organizations they serve.

A list of the grantees and contractors is provided below:

Compassion Capital Fund Demonstration Program

United Way of Massachusetts Bay	MA \$ 2,000,000
JVA Consulting, Inc.	CO \$ 1,008,547
Christian Community Health Fellowship	IL \$ 1,128,330
The National Center for Faith Based Initiative	FL \$ 700,000
Montana Office of Rural Health	MT \$ 614,555
Associated Black Charities, Inc.	MD \$ 1,500,000
Clemson University	SC \$ 1,033,341
Southeast Asia Resource Action Center	DC \$ 682,240
Community Technology Centers' Network (CTCNET)	MA \$ 1,499,770
Emory University	GA \$ 1,499,999
Operation Blessing International	VA \$ 500,000
Mennonite Economic Development Associates	PA \$ 1,000,000
Nueva Esperanza, Inc.	PA \$ 2,466,406
University of Nebraska	NE \$ 1,160,742
CJH Educational Grant Services, Inc.	NC \$ 1,506,987
Institute for Youth Development	VA \$ 2,500,000
Catholic Charities of Central New Mexico	NM \$ 1,000,000
Northside Ministerial Alliance	MI \$ 1,000,000
Volunteers of America, Inc.	VA \$ 699,159
University of Hawaii	HI \$ 600,000
S.V.D.P. Management, Inc.	CA \$ 673,041
TOTAL	\$ 24,773,117

Compassion Capital Fund Research Projects

Caliber Associates	\$236,633
Florida International University	\$210,622
University of Maryland, College Park	\$218,098
University of Pennsylvania	\$193,456

Contract Examining Services and Best Practices of Intermediary Organizations and the Faith- and Community-Based Organizations they Serve

Contractor: Branch Associates/Abt Associates (Subcontractor)

Contractor Amount: \$1.35 million

Contract to establish a National Resource Center: provide technical assistance to the CCF grantees, to facilitate collaboration among CCF intermediates, and disseminate information to the public

Contractor: Dare Mighty Things

Contractor Amount: \$2,195,000

Mr. Obey: Do you have strong performance data to support this increase request? Please describe the process of development of performance measures for this program.

Secretary Thompson: In terms of measuring performance of this young program, the Administration for Children and Families (ACF), along with the Compassion Capital Fund (CCF) contractor in charge of the National Resource Center, are developing performance measures to apply to the demonstration project grantees. The grantees are scheduled to submit evaluation plans, as requested in the original program announcement.

Branch Associates, the CCF contractor responsible for researching best practices, will include several CCF demonstration project grantees within their sample of 8 to 10 intermediary organizations. While this study does not measure performance, it will document best practices among CCF demonstration program grantees. The contract also includes analysis of how best to evaluate the effectiveness of intermediaries and faith-based organizations providing direct services, development of a bench-marking strategy for measuring the performance of faith-based and community organizations.

Mr. Obey: Is this consistent with the process for the Community Services Block Grant program?

Secretary Thompson: In the Community Service Block Grant (CSBG) program, we originally worked to develop "voluntary" performance measures with the community action agencies. This has not been as effective as we would have liked to strengthen program performance. Therefore, we are now proposing to establish national statutory outcome measures as part of the CSBG reauthorization.

Under the Compassion Capital Fund, demonstration project grantees are required to submit evaluation plans which will be used to assess their performance.

MENTORING CHILDREN OF PRISONERS

Mr. Obey: Similarly, the Administration has requested \$50.0 million for the Mentoring Children of Prisoners, an increase of over \$40.0 million over the FY 2003 appropriated level of \$9.9 million. Again, this is a very generous increase request for a new program. What is the status of the program? Have you obligated any of the FY 2003 funding? When and to whom were grants awarded?

Secretary Thompson: The Family and Youth Services Bureau within the Administration for Children and Families has developed a program announcement (RFP) soliciting applications for grant funding for the Mentoring Children of Prisoners program. The announcement is being finalized and should be published in the Federal Register in early summer.

No funding has been obligated to date. However, with the pending publication of the RFP, all grant awards and funds will be obligated by September 30, 2003. We expect to make awards to a wide range of eligible applicants, including community and faith-based organizations, State and local units of government, and Tribes.

Mr. Obey: Please provide all available performance data to support the increase request.

Secretary Thompson: The Mentoring Children of Prisoners legislation includes a requirement that grantees submit as a part of their program design, methods to evaluate outcomes for participating children. The quality of their evaluation design will be assessed as part of the grant process. The grantee must further agree to participate in the ongoing and final evaluation conducted by the Secretary that will be submitted to Congress. Grantees will be required to submit semi-annual and annual reports to the Administration for Children and Families, which will contain data that will be used in the evaluation.

Since FY 2003 will be the first year of the Mentoring Children of Prisoners program, we are unable to provide data that is specifically related to the performance of the program. However, according to the Bureau of Justice Statistics, over 2 million children currently have at least one parent in prison. Two million more have a parent on parole or on probation. A total of 6.5 million children have had at least one parent incarcerated sometime in their lifetime.

Research has found that children of incarcerated parents are seven times more likely to become involved in the juvenile justice system. These children are exposed to stress, trauma, separation and stigmatization resulting from the arrest of a parent. Compounded by existing poverty, violence, substance abuse, high-crime environments, child abuse and neglect, these young people are seriously at-risk for failure in school, confrontations with the law and lack the skills to form successful relationships.

The need is so pervasive that to do nothing will only lead to much higher rates of incarceration and a humanitarian cost as well as a financial burden on our communities and States in the future.

ADMINISTRATION ON AGING FUNDING

Mr. Obey: The President's FY 2004 budget requests a total of \$1.344 billion for all the programs funded in the Administration on Aging. This represents a reduction of \$23.0 million below the FY 2004 appropriated level of \$1.376 billion for programs helping older Americans. Data from the 2000 Census indicate that the number of older Americans eligible for the services provided by AoA may increase by an estimated 13 million to approximately 59 million individuals over 60 by the 2004-2005 time frame.

This is a 29 percent increase in the number of individuals eligible for these services. We are all well aware of the aging of the "Baby Boom" generation, why then is the Administration cutting these programs, particularly when many AoA programs already report waiting lists for services?

Secretary Thompson: While the FY 2004 budget request reflects a decrease of -\$23.3 million for AoA, virtually all of this decrease is the result of unanticipated increases in the FY 2003 enacted level. More than half of this decrease results from the completion of one-time projects. We recognize the importance of services for the aging population, which is why all AoA programs were maintained at the FY 2003 President's Budget level in the initial President's Budget request for FY 2004.

TRANSFER OF FUNDS

Mr. Obey: You are requesting an increase in your authority to transfer funds between appropriations accounts. What is the reason for the proposed increase?

Secretary Thompson: We are requesting an increase in authority to transfer funds between appropriations accounts. We propose that the Secretary have the ability to transfer up to three percent of any discretionary funds appropriated for the current year, eliminating the requirement of Congressional approval for any transfer over one percent. We also propose that the limit on the appropriation account receiving a transfer be increased from three percent to ten percent. Finally, we propose that the restriction of transferring funds only between accounts within the Labor/HHS/Education appropriation be revised to include transfers of discretionary funds between HHS appropriations in all Acts.

In these times of uncertainty and unanticipated events, it is even more important that HHS has the ability to quickly make resources available to meet priority needs. The proposed change would give the Secretary increased flexibility to move significant discretionary funds to areas of need quickly and efficiently allowing for an effective response to any contingency and enabling the carrying out of Departmental priorities. This expanded authority to transfer substantial resources in a short period of time would give HHS an additional tool to respond to major unforeseen and unanticipated events.

Mr. Obey: Have the current limits impeded transfers you believed to be necessary in previous years?

Secretary Thompson: In one instance, the current limits impeded a necessary transfer for bioterrorism activities and would have impeded another transfer had additional funds been required to address critical Year 2000 (Y2K) needs. In fiscal year 1999, a total of \$11 million was transferred to strengthen our ability to respond to a bioterrorist attack by funding further development of Metropolitan Medical Response Systems (MMRS). The funds were used to accelerate the development of MMRS in 12 additional cities and to enhance those systems already in place in 27 cities throughout

the United States. These are the same systems that played a role in responding to the terrorist attacks on September 11, 2001. Because funding for these systems was initially appropriated in the Public Health and Social Services Emergency Fund (PHSSEF) account, the PHSSEF would have been the logical place to transfer the entire \$11 million. However, only \$6.5 million of the total amount required could be transferred to the PHSSEF because of the 3 percent limit on transfers to an appropriation account. The remaining \$4.5 million had to be transferred to the General Departmental Management account so that this Secretarial priority could be fully supported.

In fiscal year 1998, a total of \$42.1 million was transferred to the Health Care Financing Administration to ensure that all Medicare contractors would be Y2K compliant. Although the amount transferred to HCFA did not exceed the maximum threshold, had the funding need been greater to bring the Medicare system under compliance, the Secretary would not have had the necessary flexibility to transfer additional funds to HCFA to address the problem.

Mr. Obey: What uses have been made in fiscal years 2001, 2002, and 2003 (thus far) of the authority granted you in annual appropriations Acts to transfer funds between appropriations accounts?

Secretary Thompson: We used the transfer authority for the following projects in fiscal years 2001 and 2002. In fiscal year 2001, HHS used the authority to transfer a total of \$9.325 million to three separate accounts: (1) \$3.1 million to the General Departmental Management (GDM) account to support enterprise infrastructure management/ information technology needs in the Department; (2) \$5 million to the Health Resources and Services account in the Health Resources and Services Administration (HRSA) to provide additional support for the Nursing Education Loan Repayment Program; and (3) \$1.225 million to NIH and the GDM account to begin implementation of an HHS Unified Financial Management System.

In fiscal year 2002, a total of \$25 million was transferred from the National Institutes of Health (NIH) to the Centers for Disease Control and Prevention (CDC). These funds were for the HHS contribution to the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, which was part of the Administration's commitment to provide \$300 million to the Global Fund by the end of FY 2002.

We are currently reviewing potential uses of the transfer authority in fiscal year 2003. However, no decisions have been made to use the authority at this time.

Mr. Obey: Please indicate the transfers made, the amounts transferred as a percentage of discretionary appropriations, and the percentage increase in the receiving accounts.

Secretary Thompson: The table below provides the requested information on transfers made, the amounts transferred as a percentage of discretionary appropriations, and the percentage increase in receiving accounts.

DEPARTMENT OF HEALTH AND HUMAN SERVICES ONE PERCENT TRANSFER AUTHORITY (Dollars in Thousands)						
OPDIVS	FY 2001 Transfer			FY 2002 Transfer		
	Out	In	% Change	Out	In	% Change
HRSA/Health Resources and Services Account	-\$188	\$5,000	0.09%			
Centers for Disease Control & Prevention	-2,936		-0.08%		25,000	0.58%
National Institutes of Health	-3,849	840	-0.01%	-25,000		-0.11%
Substance Abuse & Mental Health Svcs. Admin.	-432		-0.01%			
Agency for Healthcare Research and Quality	-61		-0.06%			
CMS/Program Management	-564		-0.03%			
Administration for Children and Families:						
Refugee and Entrant Assistance	-65		-0.01%			
Children and Family Services Programs	-254		-0.004%			
Childcare and Development Block Grant	-119		-0.01%			
Administration on Aging	-151		-0.01%			
Office of the Secretary:						
General Departmental Management	-287	3,485	1.04%			
Policy Research	-167		-1.00%			
Office of the Inspector General	-200		-0.59%			
Office of Civil Rights	-22		-0.08%			
Public Health & Social Services Emergency Fund	-30		-0.01%			
Total	-\$9,325	\$9,325	0.00%	-\$25,000	\$25,000	0.00%

EVALUATION TAP

Mr. Obey: Please provide a table showing actual or estimated sources and uses of "evaluation tap" funding under section 241 of the Public Health Service Act (as modified by annual appropriations language) for each of fiscal years 2002, 2003, and 2004.

Secretary Thompson: The information follows:

PHS Evaluation Funds, Availability and Usage

	<i>dollars in millions</i>					
	FY 2002	FY 2003		FY 2004		
		President's Budget	Enacted	President's Budget	+/- FY 2003	
Usage of Evaluation Funding						
Amount of Set-Aside	1.25%	1.25%	2.1%	1.25%		
Available.....	\$378.8	\$397.5	\$687.4	\$415.3	+\$17.8	-\$272.1
AHRQ.....	\$296.2	\$250.0	\$303.7	\$279.0	+\$29.0	-\$24.7
CDC:						
NCCHS.....	\$23.3	\$47.0	\$125.9	\$52.0	+\$5.0	-\$73.9
Other CDC.....	--	--	84.5	--	--	-84.5
HRSA.....	--	--	25.0	--	--	-25.0
NIH.....	--	--	8.2	--	--	-8.2
SAMHSA.....	--	--	74.2	16.0	+16.0	-58.2
ACF.....	--	--	6.0	--	--	-6.0
ASPE:						
Policy Research.....	\$18.0	\$18.0	\$18.0	\$21.0	+\$3.0	+\$3.0
Other ASPE.....	16.9	16.5	16.5	16.5	--	--
Subtotal, ASPE.....	\$34.9	\$34.5	\$34.5	\$37.5	+\$3.0	+\$3.0
OPHS.....	\$4.5	\$4.5	\$4.5	\$4.5	--	--
Agencies /1.....	17.8	17.8	17.8	17.8	--	--
Total Usage.....	\$376.7	\$333.8	\$684.3	\$406.8	\$53.0	-\$277.5
Remainder.....	\$2.1	\$43.7	\$3.1	\$8.5	-\$35.2	\$5.4
Sources of Evaluation Funding						
HRSA.....	\$53.1	\$47.5	\$95.1	\$51.3	+\$3.8	-\$43.8
CDC.....	34.7	31.5	57.9	34.7	+3.2	-23.2
NIH.....	273.6	260.2	304.5	302.6	+42.4	-201.9
SAMHSA.....	10.9	10.5	18.9	13.4	+2.9	-5.5
OPHS/OS /2.....	4.1	3.8	7.3	4.5	+0.7	-2.8
AoA /3.....	0.1	0.1	0.3	0.1	--	-0.2
ACF /4.....	0.2	0.2	0.3	0.2	--	-0.1
TOTAL USED.....	\$376.7	\$333.8	\$684.3	\$406.8	+\$53.0	-\$277.5
Remainder.....	\$2.1	\$43.7	\$3.1	\$8.5	-\$35.2	+\$5.4
Total Available.....	\$378.8	\$397.5	\$687.4	\$415.3	+\$17.8	-\$272.1

/1 FY 2003 and FY 2004 are estimates.

/2 Assessment includes funds appropriated to HRSA for the Family Planning Program.

/3 AoA's assessment is limited to funds appropriated for the Alzheimer's Disease Demonstration Grants which are authorized under the Public Health Service Act.

/4 ACF's assessment is limited to funds for Adoption Awareness which are authorized under the Public Health Service Act.

HOMELAND SECURITY

Mr. Obey: What specific programs and activities of the Department of Health and Human Services have been transferred to the Department of Homeland Security?

Secretary Thompson: On March 1, 2003 the new Department of Homeland Security was created. The Office of Emergency Response (formerly the Office of Emergency Preparedness) was fully transferred to DHS. This includes about 110 FTE in Headquarters and Regional Emergency Coordination staff, along with Metropolitan Medical Response System, the National Disaster Medical System, and the Noble Training Center. DHS also took over ownership of and funding responsibility the Strategic National Stockpile, including smallpox vaccines.

Mr. Obey: What transfers of funds have been made (or are intended to be made) from the Department of Health and Human Services to the Department of Homeland Security? What is the purpose, amount, and legal authority for each?

Secretary Thompson: The Determination Order related to the creation of the DHS transferred unexpended balances for the following activities: Strategic National Stockpile funded at \$298.1 million in FY 2003; smallpox vaccine activities funded at \$99.4 million in FY 2003; and the Office of Emergency Response funded at \$100.7 million in FY 2003.

The Determination Order also transferred \$3.0 million in related oversight funding to pay overhead expenses at DHS. This amount includes \$1 million from the Office of the Secretary (the Office of the Assistant Secretary for Public Health Emergency Preparedness), \$250,000 from the Office of the Inspector General, \$584,000 from CDC Capacity (Public Health and Social Services Emergency Fund), \$583,000 from NIH's National Institute for Allergy and Infectious Diseases, and a total of \$583,000 from several FDA bioterrorism activities. FDA, NIH, and CDC all have had significant responsibilities related to the Strategic National Stockpile, and FDA must expand its cooperation with the new DHS in oversight of imports of all FDA regulated products, including functions transferred from Customs and the Animal and Plant Health Inspection Service.

These transfers were carried out under sections 503 and 1516 of the Homeland Security Act of 2002. 5 USC, Part I, Chapter 9, whose operation was modified by Section 1502 of the Homeland Security Act also governed these transfers.

Mr. Obey: What is the continuing role of the Department of HHS in the National Strategic Stockpile?

Secretary Thompson: The National Strategic Stockpile will include countermeasures purchased through the stockpile appropriation, the smallpox budget activity, and the proposed BioShield authority. HHS will continue to manage the

stockpile on a day-to-day basis, and make the medical determinations with respect to what countermeasures the stockpile should contain. HHS will carry out procurements directly and, for a number of licensed products, through the Department of Veterans Affairs. Procurement of some of the new products are expected to evolve from ongoing NIH research efforts – such as a safer smallpox vaccine and a new-generation anthrax vaccine.

Mr. Obey: What are the roles of the Department of Homeland Security and the Department of Veterans Affairs with respect to the stockpile?

Secretary Thompson: The Department of Homeland Security owns, funds, and directs the disposition/use of the stockpile. The Department of Veterans Affairs is the procurement agent for a number of the licensed products.

Mr. Obey: What is the continuing role of the Department of Health and Human Services with respect to the National Disaster Medical System and Disaster Medical Assistance Teams and National Medical Response Teams? What is the role of the Department of Homeland Security?

Secretary Thompson: The National Disaster Medical System (NDMS) is the parent organization for the Disaster Medical Assistance Teams (DMATs) and the National Medical Response Teams (NMRTs). This has been a partnership between HHS, the Veterans Administration, the Department of Defense, and the Federal Emergency Management Administration. While the Department of Homeland Security (DHS) has become the lead agency for NDMS, the partnership has not changed fundamentally. While specific procedures are not yet in place, HHS (as the Lead Federal Agency for Emergency Support Function #8 in the Federal Response Plan) and DHS as the parent agency for NDMS will work closely together to deploy (or pre-deploy) appropriate NDMS assets in response to actual health and medical requirements, or to pre-deploy appropriate NDMS assets in response to intelligence estimates and/or special events requirements. DHS (not HHS) now has the authority to deploy NDMS assets.

INFLUENZA

Mr. Obey: You are requesting \$100 million in the Public Health and Social Services Emergency Fund for activities related to preparedness for pandemic influenza, as well as requesting authority to transfer an additional \$150 million in unobligated balances to this activity. I know that our preparedness for a flu pandemic is a matter of some concern among public health experts, and am pleased to see this concern reflected in your budget proposal. I would like to ask some questions about the specifics of the proposal. What specific activities would be conducted using the requested \$100 to \$250 million, and how would these activities improve preparedness to deal with a major influenza outbreak?

Secretary Thompson: This is a new effort to develop a targeted and responsive strategy to ensure the capacity to produce an adequate supply of influenza vaccine in a pandemic. Our Nation needs year-round capacity to produce vaccine, and the ability to rapidly expand production. Developing a year round domestic influenza vaccine production capacity may involve contracts with industry to maintain an egg supply in the off-season. We also seek to spur the development of production techniques that could be scaled up rapidly -- provide surge capacity -- in the event of a pandemic. This may include incentives to develop and license a cell culture influenza vaccine, and agreements on surge production for U.S. use in a pandemic.

Mr. Obey: To the extent that the proposal involves funding for activities to be carried out by vaccine manufacturers or other organizations outside the Federal Government, what specific sorts of financial assistance are contemplated, who would be the recipients, and what conditions would be placed on the assistance?

Secretary Thompson: While the current egg-based technology for influenza vaccine is efficient for annual vaccines, it is not currently set up to produce vaccine year-round, and production cannot be ramped up quickly in the event of a pandemic. Preparing for a severe pandemic could require 280 million to 575 million doses of vaccine (a two-shot series may be needed), with no more than four or five months available for manufacturing. This compares to a current annual supply of about 90 million doses, a significant portion of which is imported.

This initiative seeks to get manufacturers to make the investments needed to develop and seek licensure for culture vaccine for annual use, and set up the capacity to expand production rapidly in a pandemic. (Such a vaccine has been submitted for licensing/manufacturing in Europe, but not the U.S.) We also seek year round production capacity of currently licensed egg-based vaccines. Contracts would require that; in the event of a pandemic, the vaccine produced would be available for domestic use.

Mr. Obey: The budget justifications indicate that the requested funds could be used to develop a year-round domestic influenza vaccine production capacity, and to develop production techniques that could be scaled up rapidly. Would the Federal Government have any ownership interest in the production capacity or techniques developed as a result?

Secretary Thompson: Contractors would have an obligation to make requested pandemic flu vaccines for U.S. use. The Federal Government would not, however, have an ownership interest in the production capacity itself. Ownership interest in the cell culture production techniques are not anticipated.

Mr. Obey: What obligations to the Federal Government would be required from recipients of funding under this program?

Secretary Thompson: Contractors would be obligated to establish and maintain the desired production capacity (including surge capacity), and make pandemic flu vaccine for U.S. use upon request.

Mr. Obey: What specific provisions of authorizing law would apply to this program?

Secretary Thompson: HHS has broad responsibilities under Title XXI of the Public Health Service Act to ensure an adequate vaccine supply, and, under Section 352, authority to directly manufacture vaccines when needed and not otherwise available. Activities planned for FY 2004 are similar to past activities, including the FY 2000 contract for influenza vaccine manufacture after normal shut-down dates.

Mr. Obey: Does the Department currently have any programs underway to assist State and local health departments in planning for or otherwise preparing to deal with pandemic influenza? Are there any plans to provide such assistance in FY 2004?

Secretary Thompson: CDC has been working with States and partners for several years to improve surveillance, and develop planning guides and State/local plans. Many of the capacities needed to be prepared for an influenza pandemic are also needed for bioterrorism preparedness. The bioterrorism grants seek to upgrade state and local public health jurisdictions' preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. We expect States to prepare for pandemic influenza and other infectious disease outbreaks as part of their overall efforts. The guidance for the FY 2003 cooperative agreements to enhance state and local preparedness for bioterrorism and other public health emergencies will make explicit the availability of these funds for pandemic influenza planning.

BIOSHIELD INITIATIVE

Mr. Obey: The President's budget includes a proposal for mandatory funding for procurement of vaccines and other potential bioterrorism countermeasures under an initiative titled Project BioShield. Please describe the biomedical countermeasures procurement component of the BioShield initiative.

Secretary Thompson: The goal of the BioShield proposal is to ensure that countermeasures are developed and purchased as soon as possible. A guaranteed funding source must be made available to industry in advance of the manufacture of these products. These purchases would be driven by threat assessment. This authority would only be used if there is no significant commercial market for the product. The President could access these funds upon the joint recommendation of the Secretaries of DHS and HHS.

Estimated spending levels are displayed in the budget for the Department of Homeland Security (DHS), where the Strategic National Stockpile is funded. Contracting will be done by HHS with DHS funds--often as an extension of HHS research efforts with industry to develop new countermeasures. A specified determination process will inform priority purchase of countermeasures. The administrative costs related to these procurements will be paid out of the Strategic National Stockpile discretionary budget at the Department of Homeland Security.

Complementary proposed legislation to this authority includes advanced development authorities for the National Institute of Allergy and Infectious Diseases. This would permit expedited authority for procurements that the Secretary determines are use to perform, administer, or support biodefense research and development. Proposed legislation also authorizes the introduction into interstate commerce of certain drugs, devices or biologics for use in an actual or potential emergency, subject to the declaration of emergency by the Secretary of HHS.

Mr. Obey: Would funds be considered obligated under this program at the time contracts are entered into (which I understand to be the normal practice for Federal contracting), or would funds not be obligated until the vaccine or other countermeasure is ready for delivery?

Secretary Thompson: Funds would be obligated when the contract was entered into, with payment (outlay) upon delivery. These contracts might include options for subsequent task orders for additional quantities.

Mr. Obey: What is the rationale for the proposed use of a permanent indefinite appropriation for procurement of biomedical countermeasures, rather than a definite discretionary appropriation? What other examples currently exist of use of permanent indefinite appropriations for procurement of goods and services?

Secretary Thompson: Permanent indefinite funding is needed for products without a commercial market. A guaranteed funding source must be made available to industry in advance of the development/manufacture of these products.

First, pharmaceutical companies need to be assured that these biodefense drugs and biologics will be purchased to make it economically rational for them to develop and produce the needed countermeasures. Second, these purchases should to be driven by threat assessments. Our experience with smallpox vaccine is a good case in point. When the Administration requested in October 2001 \$0.5 billion for current-generation smallpox vaccine, the goal was to have a dose of that new vaccine for each of 286 million Americans by the end of calendar year 2002, and to have it made by at least two separate major manufacturers to ensure success. As we negotiated with potential manufacturers, it became clear decisions would have to be made on price, and only one supplier could be afforded. We now expect to have 155 million doses by June 2003. Fortunately, there was a discovery of 80 million doses of 60-year old vaccine that can be used -- diluted if necessary -- in an emergency.

Open-ended mandatory funding is used very successfully in the Vaccines for Children (VFC) program. The Pneumococcal Conjugate vaccine provides a good case study. A full course of this important vaccine costs \$184 per child, 81% of the total cost of all other routinely recommended childhood vaccines combined. This vaccine was licensed by FDA in February 2000. Once CDC's Advisory Committee for Immunization Practices recommended in June 2000 its routine use among children, sufficient funding was immediately available to procure this vaccine for children eligible for VFC, including uninsured children, Medicaid recipients, American Indians and Alaska Natives, and poorly insured children with access to community health centers or other Federally Qualified Health Centers or Rural Health Clinics.

The BioShield proposal includes significant safeguards to ensure funds are used wisely. Procurements must be jointly proposed to the President by the Secretaries of HHS and DHS, in coordination with the Director of the Office of Management and Budget. The President must approve the procurement, with the Congress notified of each such decision.

The President's budget proposes to use definite discretionary appropriations for licensed products that are commercially available and used in significant quantities in day-to-day health care. Prices are known, and costs can be projected with some level of precision to the extent that threat scenarios do not change rapidly. The budget also includes discretionary funding for added procurements of anthrax and smallpox vaccines for which there was a purchase contract in place at the beginning of this year.

Mr. Obey: What amount would you expect to obligate during fiscal year 2004 under the BioShield initiative? For what types of countermeasures?

Secretary Thompson: The President's budget estimates obligating \$890 million in FY 2004 on the new anthrax and safer smallpox vaccines NIH is developing, along with botulism antitoxin.

ABSTINENCE EDUCATION

Mrs. Lowey: The Administration has been aggressively promoting "abstinence-only" programs in lieu of traditional, comprehensive sex-education programs. Mr. Secretary, it is important to emphasize that we all support abstinence. Are you aware that a 2001 report by the National Campaign to Prevent Teen Pregnancy concluded that responsible sex and HIV-education programs that discuss both abstinence and contraception have positive results, effectively protecting teens' reproductive health? In fact, responsible sex-education programs have been proven to delay sex, reduce the frequency of sex, and increase contraceptive use. The same report found no credible evidence that abstinence-only programs delay sex or reduce its frequency. Also, the Institute of Medicine has recommended halting funding for abstinence-only programs, given that they have no demonstrated effect. "Abstinence-only programs cannot be justified...given the fact that we face an international emergency in the AIDS epidemic." Finally, the American Medical Association, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists, among other expert medical and public-health organizations, have expressed support for sex education that includes information on both abstinence and contraception. As you craft policies that affect not only our own youth, but other countries' young people too, are you, aware of the recommendations of these many prestigious organizations, including the NIH? Has the White House simply dismissed these expert opinions?

Secretary Thompson: My Department is aware of these report findings and recommendations, as well of the status of NIH research in this area. However, we are also aware that there are differences in opinion as to what we know and the quality of the evidence. There is clearly a need to generate a better scientific knowledge base from which to formulate sound policy and programs, and HHS is systematically assessing a range of approaches under varied implementation settings and using scientifically rigorous study designs.

The evaluation of abstinence programs is not complete. Indeed, many of the programs and curricula that are currently used in abstinence education have only been developed in the last five to ten years. The teen pregnancy outcomes of many local abstinence programs are promising, however peer review of the evaluation programs is pending. A comprehensive evaluation of these programs will require adequate time and funding to compare outcomes of abstinence as well as comprehensive sexuality programs. My Department is currently sponsoring an evaluation of abstinence education programs, and is in the process of designing additional studies that will add to the knowledge base about effective programs for reducing teen sexual activity, and consequently teen pregnancy and sexually transmitted diseases. While we are gathering more evidence, the Department continues to support a range of approaches to prevent teen pregnancy and sexually transmitted diseases, including both family planning and abstinence education.

Mrs. Lowey: Our Nation is facing a crisis in adolescent reproductive health. Despite the recent decline in teen pregnancy, almost 900,000 pregnancies occur among

teens aged 15-19 annually. And, at least one in every three sexually active individuals will contract an STD by age 24. Although some have argued that abstinence-only programs are behind this downward trend, in fact, the trend predates the welfare reform abstinence-only program. The Alan Guttmacher Institute's study of the teen-pregnancy trend examined the root causes of the teen pregnancy trend and discovered that three-quarters of the decline is due to increased contraceptive use, while only one-quarter is due to abstinence. In the face of these data, how can we justify funding programs that not only are less effective in achieving our goals, but in fact deliberately withhold information about what is proven to be the single most effective tool against teen pregnancy, HIV and STD infections: increased contraceptive use?

Secretary Thompson: The decline in teen pregnancy is likely due to a combination of factors and at this time those specific factors, and their degree of impact, cannot be precisely determined. It is clear from the growing number of teens choosing not to engage in sexual activity (choosing delay of sexual involvement, return to abstinence, or fewer sexual partners) that the positive message of abstinence is one of those factors. The Administration recognizes that the impact of sexual activity on adolescents extends far beyond pregnancy and sexually transmitted diseases. The message of abstinence programs and other risk avoidance initiatives is to encourage and empower teens to set goals, develop personal refusal skills, improve communication with parents and peers, and prepare for a healthy future and family.

My Department is currently sponsoring an evaluation of abstinence education programs, and is in the process of designing additional studies that will add to the knowledge base about effective programs for reducing teen sexual activity, and consequently teen pregnancy and sexually transmitted diseases. As you know, there are many programs across the nation sponsored directly or indirectly by HHS funds that provide comprehensive sexuality education or provide family planning. While we are gathering evidence, the Department continues to support a range of approaches to prevent teen pregnancy and sexually transmitted diseases, including both family planning and abstinence education.

HIV PREVENTION INITIATIVE

The President launched his International Mother and Child HIV Prevention initiative last June. In fiscal year 2003, Congress provided \$140 million for the overseas prevention of mother-to-child transmission (MTCT) of HIV, of which \$40 million was appropriated to your Department. MTCT activities have proven to be very effective and have demonstrated meaningful results in curbing a largely preventable aspect of the HIV/AIDS crisis - the transfer of HIV from mother to child. In addition, MTCT programs provide a strong base from which to extend related care and treatment services to families. I think it is critical that we move as rapidly as possible to build on the successes of MTCT programs.

Mrs. Lowey: Can you tell me how HHS plans to use these new funds as part of the President's International Mother and Child HIV Prevention Initiative?

Secretary Thompson: The \$150 million requested in CDC's budget for Preventing Mother-to-Child Transmission (PMTCT) of HIV will support the full vision of the President's Initiative – to counsel, test and treat up to one million women and reduce mother-to-child transmission of HIV among treated women by 40 percent in 14 countries in Africa and the Caribbean. HHS and the U.S. Agency for International Development (USAID) are jointly implementing the Initiative through a Steering Committee convened by the Office of National AIDS Policy (ONAP). The Department of State and the Office of Management and Budget (OMB) also participate on the Steering Committee.

The Implementation Plans include programs to support short-course and comprehensive treatment interventions, infant feeding, training of personnel and a volunteer medical corps, and standard measure for monitoring and evaluation to ensure accountability of the programs. Each country will provide a specific budget for the Initiative, which will be funded by both HHS and USAID. Therefore, HHS will use the new resources to implement the President's Initiative in full collaboration with USAID for a uniform U.S. government strategy in each country.

Mrs. Lowey: When do you expect the Department's first grants to occur?

Secretary Thompson: \$5.2 million has been disbursed from FY2002 funds to support the baseline assessments and the development of a joint HHS/USAID Implementation Plan in each one of the 14 countries participating in the Initiative. In addition, \$4 million was obligated from FY 2002 funds to four U.S. universities to support the Initiative through training and twinning activities. Eight additional countries have submitted initial Implementation plans; the Steering Committee will review these plans in April. Distribution of resources to begin implementing these plans should begin in the next few weeks. In addition to individual disbursements to countries, resources will be allocated centrally to support programs across countries for training, monitoring and evaluation and procurement. Resources for these programs will be obligated by the end of the fiscal year.

Mrs. Lowey: USAID is also involved in this initiative. How are you coordinating your efforts with the agency? What is the status of your collaboration?

Secretary Thompson: HHS and the U.S. Agency for International Development (USAID) are jointly implementing the Initiative through a Steering Committee convened by the Office of National AIDS Policy (ONAP). HHS and USAID field staff are operating as a team in each of the 14 participating countries and the Caribbean Region. Field staff from both agencies have jointly completed and submitted extensive baseline assessment of MTCT and general HIV. These assessments were completed in collaboration with major in-country partners including the Ministry of Health and non-governmental organizations. The assessments provided the framework for each country to develop a joint HHS/USAID initial Implementation Plan.

Mrs. Lowey: The President's plan also calls for treating two million and caring for 10 million HIV- infected persons. In fact, half of the new funding in the President's proposal would be devoted to treatment. Does the Administration have more information about how it plans to acquire and distribute low-cost antiretrovirals (ARVS) to Initiative countries?

Secretary Thompson: It is anticipated that funds from the President's initiative will be available to purchase products of high quality at the lowest possible cost, including but not limited to so-called 'generic' pharmaceuticals. We have not estimated the extent to which, if any, the U.S. Government itself will make these purchases, as the recipients of grants to support projects as part of the Emergency AIDS Relief Plan will likely also make the purchases of the necessary supplies.

The Administration is eager to work with all parties who are interested in contributing to this important effort to combat the global HIV/AIDS epidemic by ensuring that high-quality, affordable drugs are available to those in need of them.

SMALLPOX

Mrs. Lowey: New York City and State are struggling to pay for the costs of implementing a smallpox program. I realize HHS recently announced that States and municipalities can use 20 percent of their CDC bioterrorism funds for this cause, but this is not enough. First of all, when the bioterrorism funding was initially appropriated the smallpox program was not even on our radar screen. My city and State, therefore, obligated their funds for other chemical, biological, and nuclear attack readiness activities. Yes, I know your department will argue that not all of the fiscal year 2002 funding has been drawn down yet, but that is a reflection of the billing process, not a lack of bioterrorism preparedness investments. Furthermore, even if New City were to use 20 percent of its bioterrorism funding for smallpox preparedness, it would barely cover the bill. The cost of implementing just Phase I of the smallpox program is \$9.5 million. If New York City uses 20 percent of both its fiscal year 2002 and 2003 funding it would only add up to roughly \$8.5 million. In addition, the State and city would have to abandon other important readiness projects. Can you please respond to these concerns?

Secretary Thompson: Many of the costs included in estimates like these include work that is essential to being prepared in case a post-event vaccination campaign is ever needed. That work has always been an essential part of the bioterrorism grants. For example, New York would have needed to develop and train smallpox response teams even if no vaccinations had been recommended at this time. Similarly, information systems needed to be put in place in advance to track vaccinations and vaccine reactions. Those are costs of bioterrorism preparedness, whether or not any pre-event vaccinations are done. Having said that, I do understand the fiscal situation of State and local governments, and will continue to work with you on the issue of

vaccination costs. As part of this effort, my Department will soon provide some assistance to states from the \$100 million appropriated for smallpox vaccine administration costs in the War Supplemental.

STEPS TO A HEALTHIER US

Mrs. Lowey: I could not agree with you and the President more about the need to increase efforts to prevent chronic diseases, and was pleased to read about Steps to a Healthier US in your testimony. You describe the program as a "department-wide" endeavor. Can you please expand on that description and provide the committee with a more thorough description of this initiative?

Secretary Thompson: Steps To A Healthier US is a targeted disease prevention community initiative focusing on translating research findings into practice. The goal is preventing chronic diseases that are responsible for a major portion of the mortality in this country. The initiative seeks to reduce obesity, diabetes, and asthma-related complications. Research has shown that a healthy lifestyle- such as eating right, being active, etc. - can dramatically reduce the burden of these diseases. CDC will be the lead agency for this initiative with full participation from other agencies of the Department through a coordinating committee. A single cooperative agreement will fund States, territories, cities, communities and tribes to carry out this initiative through implementation of public health strategies. The cooperative agreement will focus on obesity, diabetes and asthma with these goals: prevent 75,000 to 100,000 Americans from developing diabetes; prevent 100,000 to 150,000 Americans from developing obesity; and; prevent 50,000 Americans from being hospitalized for asthma.

Mrs. Lowey: Can you also discuss why at the same time the Administration is touting this \$125 million effort as the key to promoting healthier living, you're cutting funding for CDC's Nutrition and Physical Activity, Chronic Disease Prevention, and Health Promotion programs - programs aimed at promoting healthy living and reducing chronic disease?

Secretary Thompson: When the FY 2004 HHS budget request was submitted, Congress had not yet completed action on the FY 2003 appropriation. In the end, Congress increased FY 2003 funding for a number of programs above the levels that had been anticipated. Apparent funding cuts to several subactivities within Chronic Disease Prevention and Health Promotion are primarily due to these unanticipated increases in the FY 2003 budget. For example, funding for the Nutrition, Physical Activity and Obesity program is requested at \$27 million, -\$7 million below FY 2003 mainly because of a higher than expected FY 2003 appropriation. Overall funding for the Chronic Disease Prevention and Health Promotion activity is requested at \$834 million, +\$44 million over FY 2003. In addition, CDC's budget structure is such that savings from management improvements are displayed in every activity line. These savings affect intramural CDC spending, not grants to States.

WISEWOMAN

Ms. Delauro: Mr. Secretary, chronic diseases such as heart disease, stroke and cancer are among the most prevalent and costly health problems. Uninsured women may be especially vulnerable to such diseases because they are less likely than their insured counterparts to receive screening for breast cancer, high blood pressure and cholesterol. Developing effective strategies for reducing these risk factors can greatly improve the health of these vulnerable women.

In 1995, the CDC initiated the WISEWOMAN program, which provides heart disease and stroke preventive services to participants in CDC's National Breast and Cervical Cancer Early Detection Program. WISEWOMAN provides breast and cervical cancer screenings to low-income and uninsured women ages 40-64 and also screens women for risk factors for heart disease--their No. 1 killer -- and for stroke -- their No. 3 killer--and provides lifestyle counseling and education as appropriate. Currently, CDC support his vital program in 11 States. How much would it take to fully-fund the WISEWOMAN program, so that all States--and the women who live in them-- will benefit?

Secretary Thompson: The WISEWOMAN demonstration program offers cardiovascular screening and counseling services to uninsured and underinsured women aged 40-64 who qualify for other services through the National Breast and Cervical Cancer Early Detection Program. The program is currently authorized to be carried out in only three States, with funding directed through the National Breast and Cervical Cancer Early Detection program. Recent appropriations bills have overridden the authorization to allow these demonstrations in more States. The FY 2004 budget contains \$10 million for 12 States and tribal groups. Set up as a demonstration, WISEWOMAN was never intended to provide services to all low-income women ages 40-64, but rather to evaluate the effectiveness of providing this set of services to this population. CDC estimates that the actual amount it would cost to fully fund WISEWOMAN in all States would be \$185 million. The breakdown for their estimate is as follows: \$147 million to state-based programs (average award of \$2.1 million); \$5 million to national organizations; \$8.7 million for prevention research; \$3 million for public and provider education; \$5.3 million for evaluation and \$16.5 million for program oversight and technical assistance. The FY 2004 budget focuses on expanding cancer screening and does not propose to expand the WISEWOMAN demonstration. It should be noted that HHS has made increased access to health care, including screening, for the uninsured a high priority through a range of programs including those in CMS and HRSA's Health Center program. The Health Center program is requested at \$1.6 billion in FY 2004, +\$122 million over FY 2003.

LIHEAP

Ms. Delauro: As the former Governor of Wisconsin, you understand the need for LIHEAP. I am very concerned about the adequacy of your proposed budget. The need for assistance is growing. In your own State of Wisconsin, for example, there was a 12 percent increase in participants this year (up from 73,857 to 82,745). In addition, prices for natural gas are up by 30 percent and heating oil prices are up by 50 percent. In my State of Connecticut alone, the average price of residential heating oil is \$1.86 per gallon – the highest residential heating oil prices in all of New England. While I am pleased that the President proposed adding \$300 million in emergency funding, I was disappointed to see a cut of \$88 million in regular funding. Shouldn't the budget be increased to address the need for assistance – both to address higher prices and increased number of applicants?

Secretary Thompson: The FY 2004 request includes a total of \$2 billion in budget authority for the LIHEAP program. This is \$212 million above the FY 2003 appropriation. While heating oil prices have spiked recently, the Department of Energy expects this to be a temporary price increase. In FY 2003, Congress rescinded \$100 million in contingency funds carried over from FY 2001 to increase funding for the base formula grant. To ensure contingency funds are available, \$300 million were requested in FY 2004 – providing the flexibility to address unexpected events, including price issues. On January 24th, 2003, for example, I was concerned with higher-than-expected fuel oil prices, so we released funds to States, and tailored the release to meet the needs of States with a higher dependence on fuel oil.

Ms. Delauro: Preliminary data suggests that we will see a significant increase in the number of households receiving shut-off notices when current State shut-off moratoriums begin expiring at the end of this month because of higher prices and continuing high unemployment. How are you planning to address the problem? Are you going to request a supplemental appropriation for LIHEAP? For example, Iowa utilities have reported a 25% increase in the number recipients with past due accounts with the total amount owed increasing by 50%.

Secretary Thompson: A LIHEAP supplemental request is not currently planned. States that have not requested 100% of their share of the FY 2003 appropriation can do so, and receive the balance of their allotment for winter use. Iowa is one of these States that could request to receive additional funding this quarter.

MENTAL HEALTH

Ms. Delauro: Mr. Secretary, I wanted to talk to you about another issue of importance to me, mental health. Recently, the President's New Freedom Commission on Mental Health released its Interim Report. Sadly, the Report found that our nation's failure to prioritize mental health is a national tragedy.

The Commission's Chairman, Michael Hogan, stated "The good news is that recovery from mental illness is a reality; a range of safe and effective treatments, services and supports exist for men, women and children with mental illness. Yet, half of all people who need treatment for mental illness do not receive it. The rate is even lower for racial and ethnic minorities and the quality of care they receive is poorer." As Secretary, what steps would you take to prioritize mental health?

Secretary Thompson: The FY 2004 budget proposal continues to maintain the Department's priority for strong mental health services programs. We are proposing increases for two populations that have critical mental health service needs - children, through the Children's Mental Health Services program, and the homeless through PATH, the Projects for Assistance in Transition from Homelessness. Further, SAMHSA continues to collaborate with other Federal organizations, such as HRSA on projects to integrate primary care with mental health, to ensure that mental health services are an integral part of their programs.

HHS is waiting to see the final report from the President's New Freedom Commission on Mental Health to guide us in responding to other critical needs. The Commission acknowledges the fragmentation issue that exists within the current system of care and we expect to be fully responsive to their recommendations.

Ms. Delauro: How does HHS propose to get treatment to more than 50 percent of our population that need it -- particularly for communities of color?

Secretary Thompson: Overall, the HHS discretionary budget includes \$2.7 billion for mental health activities. Within this total, the budget targets two of our most vulnerable and needy populations. The budget seeks a 9 percent increase for Children's Mental Health Services and a 16 percent increase for homeless individuals through PATH, the Projects for Assistance in Transition from Homelessness. We also support States through the Mental Health Block Grant, which provides treatment to over 220,000 individuals. The Block Grant is currently moving to a Performance Partnership with the States, which will emphasize accountability and client level outcomes, and provide more State flexibility. States are continuing to provide the bulk of the support for mental health services through other resources and funding streams, such as Medicaid, State revenues, housing, employment, education, etc. In addition, the SAMHSA discretionary portfolio, especially the Targeted Capacity Expansion State Incentive Grant program, focuses on underserved populations in each State and targets resources to those most in need. Finally, the enormous investment in technical assistance to the States and the numerous faith-based and community service organizations allow evidence-based model programs to move "Science to Services" resulting in higher quality services, better interventions, and positive outcomes for people with mental illness. SAMHSA is also dedicated to serving minority populations, and has specified mental health funding for services and activities for communities of color. There is \$10 million, a 22 percent increase, targeted to

addressing mental health concerns for minorities with HIV/AIDS, and \$12.5 million, a 15 percent increase, in the Center for Mental Health Services designated for mental health services and activities in communities of color.

The Department is committed to providing quality mental health services to communities of color. Within the budget, we are seeking an increase of \$63.6 million. Examples of research being conducted are: assessing risk factors for suicide, with an emphasis on interventions for underserved populations, and research to develop culturally appropriate mental health interventions and services.

Ms. Delauro: Finally, I applaud the Commission for highlighting the importance of intervening early to prevent mental health problems, its recognition of the important role that schools can play in provision of mental health services, and its acknowledgment of the need to expand model wraparound-services to children who are at risk of more serious problems if their needs are not recognized and treated. What actions would you consider to deliver mental health services in a place long overlooked (as indicated in the report) -- our Nation's schools?

Secretary Thompson: HHS/SAMHSA is collecting data and supporting grants to improve the effectiveness of mental health services in school systems. This program includes a major joint initiative with the Departments of Education and Justice. SAMHSA has worked to ensure that mental health promotion, prevention of emotional and behavioral disorders, mental health treatment, and substance abuse prevention and early intervention are key components of this interdepartmental initiative entitled, "Safe Schools/Healthy Students." The current 143 Safe Schools/Healthy Students (SS/HS) funded projects address all six of the following programmatic elements in implementing their three-year, comprehensive plans: (1) school safety, (2) alcohol and other drug and violence prevention and early intervention programs, (3) school and community mental health preventive and treatment intervention services, (4) early childhood psychosocial and emotional development programs, (5) educational reform, and (6) safe school policies. In addition, all grantees are implementing activities and programs in each area that are based on the best evidence available about their effectiveness.

The mental health component of the SS/HS initiative has two purposes: (1) to provide mental health preventive services early to reduce risk of onset or delay the onset of emotional and behavioral problems for some children; and, (2) to identify those children who already have serious emotional disturbance and ensure that they receive appropriate referral, treatment, and follow-up services.

SAMHSA is currently conducting the first national survey to collect information on school mental health services. The results of this survey will enable us to understand the mental health treatment resources available in schools and the nature of the services that are provided.

TITLE VII HEALTH PROFESSIONS FUNDING

Ms. Delauro: While I applaud the President's recommended increases for the National Health Service Corps and Community Health Center programs, I'm concerned that with the drastic cuts made to the Title VII and VIII programs, our health care providers may not be prepared to provide the quality care the country deserves. How do you plan to ensure the continued success of the National Health Service Corps and Community Health Center programs without strong support for the Titles VII and VIII programs?

Secretary Thompson: We believe this increase in the National Health Service Corps will enable us to meet the increased Health Center staffing needs created by the President's Initiative. We are investing in programs that provide direct health care service to underserved communities, and that address the current challenges facing the health professions workforce. For FY 2004, we are requesting \$1.6 billion for the Health Center Initiative, an increase of \$122 million, for the third year of the President's Health Center Initiative. By 2006, we will have created an additional 1,200 new and expanded health center sites serving an additional 6 million people. We are also seeking significant investments in the National Health Service Corps. Over 50 percent of National Health Service Corps providers meet their service obligation at our health centers. Our request of \$213 million, a 24 percent increase, will support a total field strength of 4,300 health care providers.

Along with our increases in the Health Center Program and the National Health Service Corps, we maintain a significant investment of \$98 million in Title VIII nurse workforce development programs, in order to address the nursing shortage. We also provide a \$32 million increase, for a total of \$60 million, to train and prepare health care professionals to recognize symptoms and treat patients in the event of a biological, chemical, or nuclear attack.

HEALTH PROFESSIONAL TRAINING

Ms. Delauro: Those who work in Community Health Centers are pleased that the administration budget recognize the important role they play in the health care of Americans, but the question still remains of how to train staff to work in these unique interdisciplinary settings. The Title VII- funded Area Health Education Center (AHEC) programs, in particular, are interdisciplinary training settings that allow for the provision of health care services to the disadvantaged. In Connecticut the AHECs recruit middle and high school students into the field of nursing and allied health professionals, whose shortages plague our State. Additionally, they undertake a variety of actions to retain the professionals in the workforce. These essential functions will not be sustainable or replaceable without the continued support of the Federal Government. How will nurses, physicians and other providers be trained so that they have the skills necessary to provide care to CHC patients if funding for Area Health Education Centers is eliminated, as is proposed in the President's Budget?

Secretary Thompson: The President's Budget is investing in programs that provide direct health care service to underserved communities, and that address challenges facing the health professions workforce. Over the past two decades more than \$6 billion has been invested in Title VII health professions training and most of these programs have not directly increased services to underserved populations. State and local entities provide significant funding to AHEC programs and centers within their individual States to respond to State and local needs as well as Federal priorities. The AHEC community-based training programs at rural and urban underserved area sites have been well received and it is anticipated that they will be supported by State and local resources in the future. We will continue to monitor health care workforce training and education and be ready to respond should shortages or problems emerge.

CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION (GME)

Ms. Delauro: Mr. Secretary, since 1999, Congress has worked hard, on a bipartisan basis, to provide equitable graduate medical education funding for the Nation's independent children's hospitals. Through their academic and clinical programs, these institutions directly or indirectly touch the lives of every child in the country. I am proud to be a strong supporter of the Federal Children's Hospitals GME Program in HRSA, which last year provided more than \$4 million in critically needed support for the education mission of Connecticut Children's Medical Center in Hartford. Why has the Administration proposed to cut funding for the program by nearly a third - from \$292 million to \$199 million at a time when children's hospitals face extraordinary financial challenges in every State? Such a cut could seriously harm their ability to serve all children.

Secretary Thompson: Since FY 2000, when the Children's Hospitals Graduate Medical Education Payment Program was initiated, Congress has expanded the program seven-fold, going from \$40 million up to \$290 million in FY 2003. Our proposal for FY 2004 is a modest effort to restrain spending. It should be noted that these funds subsidize the training of physicians at children's hospitals, and are not intended to provide services directly to children. Even with this reduction in GME payments, the approximately 60 free-standing children's hospitals in the country would receive estimated payments of \$52,000 per resident.

NEWBORN SCREENING

Ms. Delauro: Mr. Secretary, your home State of Wisconsin has one the strongest newborn screening programs in the country, testing infants for over 20 heritable disorders. My home State of Connecticut is one of the 14 or so States which tests for at least eight heritable disorders - and our public health officials are desperately seeking the resources to expand to include additional tests now. By contrast, over one-half of all States test for only five or fewer heritable disorders. As a result, there have been some tragic stories of children dying from certain disorders that the State newborn screening program did not test for, but had the child been screened under another State's

more comprehensive newborn screening program, the disorder would have been detected and easily treated. Under Title 26 of the Children's Health Act of 2000, HHS is authorized to provide grants to States so that they can keep up with the latest in screening technologies to improve their newborn screening programs to help eliminate the screening gap. For the second year in a row, last year's Labor-HHS-Education appropriations act included language expressing support for HRSA to implement this program, but for the second consecutive year, the Administration's budget does not provide a nickel to fund Title 26 grants.

Mr. Secretary, as I have stated before, in the greatest, most prosperous country in the world, the health of your child shouldn't depend on your particular zip code. Not only does newborn screening save lives, but it also saves public dollars that would have to be spent on treatment for advanced disorders. I raised this issue with you last year, and would like to get a firm commitment from you to support the efforts of a bipartisan group of members who want to fund Title 26 this year. We need to stop talking about the merits of this program and start funding it. Members of this Committee who have supported the newborn screening program include my colleagues Mr. Cunningham, Mr. Istook, Mr. Murtha, Mr. Hoyer, Ms. Roybal-Allard and me. There is also bipartisan support for this program in the Senate. Together, we can help ensure that all children receive these simple, and in many instances, lifesaving blood tests. We should do no less. The FY 2004 budget eliminates funding for newborn hearing screening and provided no funds for Title 26 of the Children's Health Act of 2000 to provide assistance to State to expand their newborn screening programs for metabolic diseases. This screening provides early identification of infants affected by certain genetic, metabolic, hormonal, and or functional conditions for which there may be an effective treatment or intervention. If left untreated, these disorders can cause death, disability, mental retardation, and other serious illnesses. I am pleased that you have increased the MCH block grant (by \$19 million) but this additional funding will not be enough to provide funding for newborn screening so important to our Nation's youngest children. In these economic times, you know States are hard pressed to fund these crucial programs, how can we explain not funding these programs?

Secretary Thompson: While we are not requesting specific funds for the Universal Newborn Hearing Screening program in HRSA, the Department continues to be committed to strengthening the Nation's newborn screening system.

The Maternal and Child Health Block Grant, which we increased by \$21 million in FY 2004, for a total of \$751 million, provides States the flexibility to fund services like newborn hearing screening. Through the Maternal and Child Health Block Grant's Special Projects of Regional and National Significance, funding will continue to be provided to States to enhance their capacity to better integrate their newborn screening programs with the State Title V community-based system of services for Children with Special Health Care Needs. Federal dollars through Medicaid, which reimburses for newborn screening services for eligible infants, provides another funding option that States can utilize for the over one-third of all births that are Medicaid eligible.

Technical assistance, screening technology training and educational resources will also be available through the MCHB-funded National Newborn Screening and Genetics Resource Center to support States in their newborn screening efforts.

On February 3, 2003, I approved the establishment of the Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns and Children as a first step in implementing Title XXVI of the Children's Health Act of 2000. Specifically authorized by the Act, the Committee will provide advice and consultations to me on matters related to grants and projects authorized by the Act and the development of policies and priorities that will reduce mortality or morbidity from heritable disorders.

FOOD SAFETY/BIOTERRORISM

Ms. Delauro: Two days ago, Secretary Ridge announced the creation of Operation Liberty Shield, a plan to increase security for the homeland. Along with a variety of other efforts, the Secretary mentioned food safety as part of this plan. Specifically, he mentioned that there will be "greater inspection of imported food" and that food security will be part of this coordinated, national plan. Is FDA part of Operation Liberty Shield? How are you contributing to the plan?

Secretary Thompson: In FDA's continuing efforts to ensure the safety and security of the nation's food supply, just yesterday, they issued new security guidance as part of Operation Liberty Shield. FDA announced the availability of four guidance documents designed to help manufacturers minimize the risk of tampering or other malicious, criminal or terrorist actions. FDA also announced increased surveillance of domestic and imported foods, and enhanced collaboration with other government agencies as part of its Liberty Shield Initiatives.

Ms. Delauro: My understanding is that FDA currently is only able to inspect a little over 1% of imported foods, even with the additional inspectors you received from the FY 2002 supplemental. What percentage of food imports are you able to inspect?

Secretary Thompson: Food imports inspections will remain at the heightened levels to be achieved in FY 2003. Physical examinations at ports of entry are increasingly using new portable biosensors, radiation detectors, etc., but as important as direct examinations are, we are currently considering other ways to build upon direct examinations of imports to ensure our food supply is safe. A new registration system is being put in place, and recent law changes will help target our efforts by providing advance notice of planned imports. There are activities we can undertake, such as working with foreign countries and foreign producers, on the front end, in how the goods are produced, and how they are packaged and sent to this country to ensure our food supply is safe. FDA is developing a strategic plan, which we expect to have out this year, that takes a comprehensive approach to evaluating the production and shipment of imports, and considers more cost-effective means to achieving the same end.

Ms. Delauro: Do you have the necessary resources to protect the public health?

Secretary Thompson: In our proposed budget, FDA's overall food safety request – which is much broader than the Bioterrorism-specific activities – increases by \$2.6 million for a total FDA food safety budget of \$515.5 million. The request includes a \$20.5 million increase, partially offset by management savings for Bioterrorism-specific food safety activities. This is the largest amount of spending we have ever had for food security and reflects a substantial increase over where our budget was just a couple of years ago before big increases in our inspection personnel and other food security support staff. I expect FDA to have a comprehensive import strategic plan out this year, reflecting FDA's recently expanded authorities, recent funding increases, and regulations being implemented to take us to a new level of security and confidence with respect to the foods that we import.

Ms. Delauro: How will you comply with Secretary Ridge's call to have greater inspection of imported foods?

Secretary Thompson: In FDA's continuing efforts to ensure the safety and security of the nation's food supply, just yesterday, they issued new security guidance as part of Operation Liberty Shield. FDA announced the availability of four guidance documents designed to help manufacturers minimize the risk of tampering or other malicious, criminal or terrorist actions. FDA also announced increased surveillance of domestic and imported foods, and enhanced collaboration with other government agencies as part of its Liberty Shield Initiatives.

Ms. Delauro: With the creation of Operation Liberty Shield, has there been any discussion about looking at the possibility of creating a single food agency?

Secretary Thompson: We have thought very hard about this. We had an interagency group work on the issue last year. At the conclusion of the process last fall, the recommendation was that now is not the time to push for a single food agency, but that we need to continue efforts to ensure the different agencies with responsibilities over food safety are working together as effectively as possible. We continue to be focused on this matter now and working with the other agencies involved in ensuring our food supply is safe. We have made tremendous strides during my tenure to ensure the safety of food FDA regulates, and I seek to continue building upon those successes.

Ms. Delauro: With the threat of a bioterrorist attack on our food supply, do you think it's time we looked at consolidating our food safety system into one agency?

Secretary Thompson: The Administration has looked at this, and a conclusion has been reached that now is not a good time to push for a single food agency. There was a lot of consideration given to this matter by me, some of my colleagues, and others in the Administration who have been involved in food safety issues. We concluded it would be best to focus efforts to identify any remaining gaps and address them so we are

effective in ensuring that our nation's food supply is protected. We have made tremendous strides during my tenure to ensure the safety of food FDA regulates, and I seek to continue building upon those successes.

PEDIATRIC RULE

Ms. Delauro: As you know, yesterday the Senate Health and Education Committee unanimously voted out legislation to restore the pediatric rule. While I and many members of the committee (the amendment vote was along party lines) were very disappointed that the bill was amended to time limit the authority of the FDA to require that drugs be tested for children, that vote was an important step in moving the bill forward and I hope that the House will act quickly on this legislation. Has the Administration endorsed this legislation?

Secretary Thompson: The Administration provided Congress the principles we endorse in establishing FDA's authority to require pharmaceutical manufacturers to conduct appropriate pediatric clinical trials on new drugs and biologics.

Ms. Delauro: The Administration has stated that "public health will be best served by enabling the FDA to require testing of drugs for pediatric use" (quote from 12/16/02 HHS press release). Does that mean that the Administration will oppose "sun setting" that authority?

Secretary Thompson: The Administration supports codification of the Pediatric Rule which did not have a "sunset". We want to make sure that it is done as soon as possible because there are studies not being performed now. We need action right away to get this enacted into law, and I appreciate your support for that.

Ms. Delauro: Why would we time limit the authority of the FDA to make sure medicines are safe for children when we don't time limit their authority to protect adults?

Secretary Thompson: The Administration supports codification of the Pediatric rule which did not have a time limit on the authority of FDA to make sure medicines are safe for children. However, we have worked with members and staff to communicate our support for legislation that gives FDA the authority to make sure medicines are safe for children.

AUDIOLOGY

Ms. Delauro: Mr. Secretary, as you know, CMS still has two different definitions of who is a qualified audiologist, one for Medicare and one for Medicaid. I appreciate that you are trying to fix this problem. When do you think we might finally see a proposed Medicaid regulation? It has been two years since you said you would "get it done."

Secretary Thompson: This regulation was published in the *Federal Register* on April 2. This proposed rule would revise the requirements for audiologists furnishing services under the Medicaid program. In addition, it would create consistency with the Medicare requirements that define a qualified audiologist by recognizing the role of State licensure in determining provider qualifications. These revised standards would expand State flexibility in choosing qualified audiologists (*NB*: This proposed rule can be found at www.access.gpo.gov/su_docs/fedreg/a030402c.html).

DRUG IMPORTS

Ms. Delauro: Secretary Thompson, I know that you have been asked on several occasions about the Department's position with respect to the import of prescription drugs from Canada. You have previously indicated that you are satisfied with the Canadian laws and the Canadian manufacturing processes and practices. As you are aware, hundreds of thousands of Americans import drugs from Canadian pharmacies. As long as there is documentation that a U.S. physician has prescribed the drug, that the drug is for personal use, and that there is no more than a 90-day supply, border agents from the Food and Drug Administration and the Customs Department permit the drugs to be imported into the U.S. This is the general rule, although I understand there are specific exceptions for controlled substances and certain other drugs about which the FDA may have specific concerns. As I am sure you understand, among Americans who order these drugs, there is concern about whether the FDA will exercise its enforcement discretion consistently. Can you assure this Committee for the record that the FDA has consistently exercised its enforcement discretion to permit the import of drugs for personal use under the conditions I have described and that it will continue to do so?

Secretary Thompson: First of all, the United States Federal Food, Drug and Cosmetic Act prohibits the interstate shipment of unapproved new drugs. The importation of drugs that lack FDA approval, whether for personal use or otherwise, violates that Act. Unapproved new drugs are any drugs, including foreign-made versions of U.S. approved drugs, that have not been manufactured in accordance with and pursuant to an FDA approval. The importers have an obligation to demonstrate to FDA that any drugs offered for importation have been approved by FDA.

Regarding enforcement discretion and when personal importation of drugs is allowed, FDA and U.S. Customs Service have consistently collaborated in examination efforts. The U.S. Customs Service (not FDA) is responsible for examining personal baggage and parcels. In their examinations, Customs looks for FDA-regulated items intended for commercial distribution, items FDA specifically requested be detained, or any FDA regulated items that appear to represent a health fraud or an unknown risk to health. FDA personnel use their discretion on a case by case basis in determining whether to detain, refuse or allow entry of items brought to their attention by Customs.

When deciding whether to exercise discretion to allow personal importation of drugs, FDA personnel may consider whether the following apply:

- The intended use is unapproved and for a serious condition for which effective treatment may not be available domestically either through commercial or clinical means;
- There is no known commercialization or promotion to persons residing in the U.S. by those involved in the distribution of the product at issue;
- The product is considered not to represent an unreasonable risk; and
- The individual seeking to import the product affirms in writing that it is for the patient's own use (i.e. no more than a 90 day supply) and provides the name and address of the U.S.-licensed doctor responsible for treatment or provides evidence that the product is for the continuation of a treatment begun in a foreign country.

With this criteria as their guidance, FDA has consistently exercised its enforcement discretion, and will continue to do so.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR
2004

General Departmental Management
Policy Research
DM GPRA Performance Plans
Public Health & Social Services Emergency Fund (PHSSEF)
HHS General Provisions

Justification of Estimates for
Appropriations Committees

DEPARTMENT OF HEALTH AND HUMAN SERVICES

GENERAL DEPARTMENTAL MANAGEMENT

POLICY RESEARCH

PUBLIC HEALTH AND SOCIAL SERVICES
EMERGENCY FUND

HHS GENERAL PROVISIONS

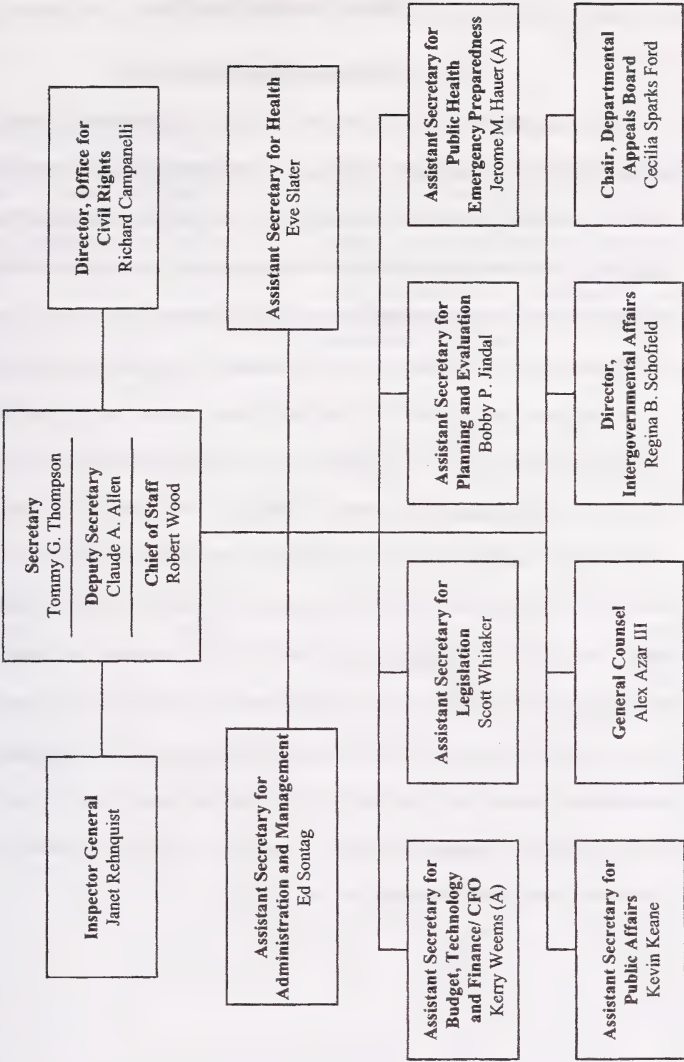
	2004 Estimate		
	FTE	Budget Authority	Page
General Departmental Management	1,364	\$353,951,000	3
Service and Supply Fund (OS portion only)	42	—	152
Policy Research	37	\$2,499,000	167
Public Health and Social Services Emergency Fund	<u>89</u>	<u>\$1,896,149,000</u>	289
TOTAL, Departmental Management	1,532	\$2,252,599,000	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
GENERAL DEPARTMENTAL MANAGEMENT

<u>FY 2004 Budget</u>	<u>Page</u>
Organization Chart	5
Appropriation Language and Analysis	6
Amounts Available for Obligation	8
Summary of Changes	9
Budget Authority by Activity	11
Budget Authority by Object	12
Salaries and Expenses	14
Significant Items in Appropriations Committee Reports	16
Authorizing Legislation	27
Appropriations History Table	28
Justifications:	
General Statement	30
Immediate Office of the Secretary	33
Assistant Secretary for Public Affairs	35
Assistant Secretary for Legislation	37
Assistant Secretary for Planning and Evaluation	39
Assistant Secretary for Budget, Technology and Finance	41
Assistant Secretary for Administration and Management	47
Office of Intergovernmental Affairs	53
Office of the General Counsel	55
Departmental Appeals Board	71
Office on Disability	78
Office of Global Health Affairs	80

Office of Public Health and Science	85
OPHS Immediate Office	90
Office of HIV/AIDS Policy	93
Office of Population Affairs/Adolescent Family Life	95
Office of Disease Prevention and Health Promotion	98
President's Council on Physical Fitness and Sports	104
Office of Minority Health	106
Office on Women's Health	118
Office for Human Research Protections	131
Transformation of the Commissioned Corps	137
Commissioned Corps Readiness Force	139
Office of Research Integrity	141
Rent and Common Expenses	147
Unified Financial Management System (GDM payment only)	150
HHS Service and Supply Fund	153
HIV/AIDS in Minority Communities	156
Information Technology Security and Innovation Fund	158
Detail of Full-Time Equivalent (FTE) Employment	160
Detail of Positions	161
New Positions Requested	163
Centrally-Managed Projects	164

OFFICE OF THE SECRETARY



APPROPRIATION LANGUAGE

For necessary expenses, not otherwise provided, for general departmental management, including hire of six sedans, and for carrying out titles III, XVII, and XX of the Public Health Service Act, and the United States-Mexico Border Health Commission Act, [\$301,703,000] \$348,100,000, together with \$5,851,000 to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Hospital Insurance Trust Fund and the Supplemental Medical Insurance Trust Fund: *Provided*, That of the funds made available under this heading for carrying out title XX of the Public Health Service Act, \$11,885,000 shall be for activities specified under section 2003(b)(2), of which \$10,157,000 shall be for prevention service demonstration grants under section 510(b)(2) of title V of the Social Security Act, as amended, without application of the limitation of section 2010(c) of said title XX: *Provided further*, That of this amount \$50,000,000 is for minority AIDS prevention and treatment activities; and [\$21,998,000] \$18,400,000 shall be for an Information Technology Security and Innovation Fund for Department-wide activities involving cybersecurity, information technology security, and related innovation projects, and \$5,000,000 is to assist Afghanistan in the development of maternal and child health clinics, consistent with section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002. (Department of Health and Human Services Appropriations Act, 2002, as enacted by Title II of PL 107-116.)

LANGUAGE ANALYSIS

Language ProvisionExplanation

"and \$5,000,000 is to assist Afghanistan in the development of maternal and child health clinics, consistent with section 103(a)(4)(H) of the Afghanistan Freedom Support Act of 2002 "

The FY 2004 request includes an increase of \$5,000,000 to support a joint HHS/ DoD initiative to improve the largest women's hospital in Kabul, Afghanistan, and to create four satellite teaching clinics for maternal and child health care. This language specifies the amount of funding to be made available for this effort.

AMOUNTS AVAILABLE FOR OBLIGATION¹

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>
<u>General funds:</u>			
Annual appropriation	\$341,703,000	\$387,880,000	\$348,100,000
Rescission pursuant to PL 107-116	-502,000	-	-
Rescission pursuant to PL 107-206	<u>-1,165,000</u>	<u>-</u>	<u>-</u>
Subtotal	340,036,000	387,880,000	348,100,000
Comparable transfers to:			
Other HHS Operating Divisions, for proposed consolidation of Public Affairs and Legislation functions	-	-27,793,000	-
Accrued retirement cost proposal	<u>-</u>	<u>-9,336,000</u>	<u>-</u>
Subtotal	340,036,000	350,751,000	348,100,000
Real transfer from:			
Office for Civil Rights, for consolidation of administrative functions	+376,000	+385,000	-
Real transfer to:			
Department of Homeland Security, for Office of Emergency Preparedness/Response (net of Commissioned Corps Readiness Force)	<u>-12,960,000</u>	<u>-13,947,000</u>	<u>-</u>
Subtotal, adjusted general funds	327,452,000	337,189,000	348,100,000
<u>Trust funds:</u>			
Annual appropriation	<u>+5,851,000</u>	<u>+5,851,000</u>	<u>+5,851,000</u>
Subtotal, adjusted trust funds	5,851,000	5,851,000	5,851,000
Subtotal, adjusted budget authority	333,303,000	343,040,000	353,951,000
Unobligated balance lapsing	<u>-2,227,000</u>	<u>-</u>	<u>-</u>
Total obligations	\$331,076,000	\$343,040,000	\$353,951,000

¹ Excludes the following amounts for reimbursable activities carried out by this account: FY 2002 – \$145,981,000; FY 2003 – \$151,426,000; FY 2004 – \$166,052,000.

SUMMARY OF CHANGES

2003	Request – General funds (adjusted)	\$337,189,000
	Request – HI/SMI trust funds transfer	<u>5,851,000</u>
	Total adjusted budget authority	343,040,000
2004	Request – General funds	348,100,000
	Request – HI/SMI trust funds transfer	<u>5,851,000</u>
	Total estimated budget authority	\$353,951,000
	Net change	+\$10,911,000

	2003 Current		Change from Base	
	<u>Estimate</u>	<u>Base</u>	<u>Change</u>	<u>from Base</u>
	(FTE)	Authority	(FTE)	Authority
Increases:				
A. Built-in:				
1. Annualization of January 2003 pay raise (3.1%)	(1,375)	\$116,535,000	(–)	+\$903,000
2. Effect of January 2004 pay raise (2.0%)	(1,375)	116,535,000	(–)	+1,748,000
3. Within-grade increases and career ladder promotions ..	(1,375)	116,535,000	(–)	+1,093,000
4. Total RENT Payments to GSA	(–)	14,531,000	(–)	+1,262,000
5. Total RENT Related Services	(–)	3,633,000	(–)	<u>+1,483,000</u>
Subtotal				+6,489,000
B. Program:				
1. Increase for maternal and child health care initiative in Afghanistan	(–)	–	(–)	+5,000,000
2. Increase for Transformation of the Commissioned Corps	(–)	–	(–)	+5,000,000

SUMMARY OF CHANGES
(Cont.)

	2003 Current		Change from Base	
	<u>(FTE)</u>	<u>Budget Authority</u>	<u>(FTE)</u>	<u>Budget Authority</u>
3. Increase for UFMS payment	(-)	\$1,029,000	(-)	+\$764,000
4. All other inflationary and program-related increases for GDM Staff Divisions	(-)	183,535,000	(-)	<u>+838,000</u>
Subtotal			(-)	+11,602,000
Total increases			(-)	+18,091,000

Decreases:A. Built-in:

1. Delegated Authority	(-)	4,806,000	(-)	-1,627,000
------------------------------	-----	-----------	-----	------------

B. Program:

1. IT Security and Innovation Fund	(-)	20,000,000	(-)	-1,600,000
2. Other "right-sizing" and IT reductions	(-)	183,535,000	<u>(-11)</u>	<u>-3,953,000</u>
Subtotal			(-11)	-5,553,000
Total decreases			(-11)	-7,180,000
Net change			(-11)	+\$10,911,000

General Departmental Management

BUDGET AUTHORITY BY ACTIVITY
(Dollars in thousands)

	FY 2002 <u>Actual</u>		FY 2003 <u>Pres Budget</u>		FY 2004 <u>Estimate</u>	
	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>
Immediate Office of the Secretary	69	\$7,587	69	\$7,999	68	\$8,235
Public Affairs	33	3,751	35	4,064	34	4,155
Legislation	26	2,877	28	3,161	28	3,244
Planning and Evaluation	79	6,511	95	6,993	95	7,019
Budget, Technology and Finance	129	19,218	144	20,117	148	20,588
Administration and Management	131	15,881	156	16,696	150	17,100
Intergovernmental Affairs	40	5,622	47	6,108	45	6,130
General Counsel	347	35,593	344	39,268	342	39,412
Departmental Appeals Board	72	8,079	76	8,902	73	8,935
Office on Disability	-	-	3	350	3	351
Global Health Affairs	55	4,293	56	4,310	56	9,310
Public Health and Science	299	131,188	312	134,174	312	139,184
President's Council on Bioethics	10	-	10	-	10	-
RENT/Del Auth and Related Services ¹	-	10,986	-	11,821	-	12,765
Common Expenses/ SSF Payment ¹	-	7,000	-	8,548	-	7,815
UFMS Payment	-	74	-	529	-	1,293
Transportation Grant	-	998	-	-	-	-
NAS Studies	-	499	-	-	-	-
Other One-Time Projects	-	1,195	-	-	-	-
Minority HIV/AIDS	-	49,991	-	50,000	-	50,000
IT Security and Innovation Fund	-	<u>21,960</u>	-	<u>20,000</u>	-	<u>18,400</u>
Subtotal	1,290	\$333,303	1,375	\$343,040	1,364	\$353,951
OS Service and Supply Fund	<u>42</u>	<u>-</u>	<u>42</u>	<u>-</u>	<u>42</u>	<u>-</u>
Total budget authority	1,332	\$333,303	1,417	\$343,040	1,406	\$353,951
[Trust Fund transfers included above] ..		[\$5,851]		[\$5,851]		[\$5,851]
[1% Evaluation Funds; non-add]		[\$21,552]		[\$21,552]		[\$21,552]

¹ Excludes OGC, OPHS, IGA, DAB and OGHA shares; see page 147.

BUDGET AUTHORITY BY OBJECT

	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Full-time equivalent employment	1,375	1,364	-11
Average SES salary	\$126,272	\$129,144	+\$2,873
Average GS grade	12.1	12.1	—
Average GS salary	\$67,444	\$68,978	+\$1,534
Personnel compensation:			
Full-time permanent	\$87,697,000	\$90,445,000	+\$2,748,000
Other than full-time permanent	3,097,000	3,172,000	+75,000
Other personnel compensation	<u>4,731,000</u>	<u>4,885,000</u>	<u>+154,000</u>
Subtotal, personnel compensation	95,525,000	98,502,000	+2,977,000
Civilian personnel benefits	20,224,000	20,948,000	+724,000
Benefits to former personnel	<u>786,000</u>	<u>829,000</u>	<u>+43,000</u>
Subtotal, Pay costs	116,535,000	120,279,000	+3,744,000
Travel	2,692,000	2,641,000	(51,000)
Transportation of things	186,000	174,000	(12,000)
Rental payments to GSA	14,531,000	15,793,000	+1,262,000
Rental payments to others	87,000	88,000	+1,000
Communications, utilities, miscellaneous charges	4,059,000	4,068,000	+9,000
Printing and reproduction	1,724,000	1,699,000	(25,000)
Other contractual services:			
Advisory and assistance services	200,000	202,000	+2,000
Other services	40,476,000	47,193,000	+6,717,000

General Departmental Management

	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Purchases of goods and services from Government accounts	\$24,673,000	\$25,873,000	+\$1,200,000
Operation and maintenance of facilities	2,973,000	2,892,000	(81,000)
Research and development contracts ..	309,000	289,000	(20,000)
Medical care	—	—	—
Operation and maintenance of equipment	23,162,000	21,473,000	(1,689,000)
Subsistence and support of persons ...	—	—	—
Subtotal, other contractual services ..	91,793,000	97,922,000	+6,129,000
Supplies and materials	1,720,000	1,724,000	+4,000
Equipment	1,774,000	1,717,000	(57,000)
Grants, subsidies and contributions	<u>107,939,000</u>	<u>107,846,000</u>	<u>(93,000)</u>
Subtotal, Non-pay costs	226,505,000	233,672,000	+7,167,000
 Total, Budget Authority	 \$343,040,000	 \$353,951,000	 +\$10,911,000

SALARIES AND EXPENSES
(Budget Authority)

	<u>FY 2003</u> <u>Pres Budget</u>	<u>FY 2004</u> <u>Estimate</u>	<u>Increase or</u> <u>Decrease</u>
Personnel compensation:			
Full-time permanent (11.1)	\$87,697,000	\$90,445,000	+\$2,748,000
Other than full-time permanent (11.3) ...	3,097,000	3,172,000	+75,000
Other personnel compensation (11.5/11.8)	<u>4,731,000</u>	<u>4,885,000</u>	<u>+154,000</u>
Subtotal, personnel compensation (11.9)	95,525,000	98,502,000	+2,977,000
Civilian personnel benefits (12.1)	20,224,000	20,948,000	+724,000
Benefits to former personnel (13.0)	<u>786,000</u>	<u>829,000</u>	<u>+43,000</u>
Subtotal, Pay costs	116,535,000	120,279,000	+3,744,000
Travel (21.0)	2,692,000	2,641,000	(51,000)
Transportation of things (22.0)	186,000	174,000	(12,000)
Rental payments to others (23.2)	87,000	88,000	+1,000
Communications, utilities, miscellaneous charges (23.3)	4,059,000	4,068,000	+9,000
Printing and reproduction (24.0)	1,724,000	1,699,000	(25,000)
Other contractual services:			
Advisory and assistance services (25.1) ..	200,000	202,000	+2,000
Other services (25.2)	40,476,000	47,193,000	+6,717,000
Purchases of goods and services from Government accounts (25.3)	24,673,000	25,873,000	+1,200,000
Operation and maintenance of facilities (25.4)	2,973,000	2,892,000	(81,000)
Research and development contracts (25.5)	309,000	289,000	(20,000)

General Departmental Management

	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Medical care (25.6)	—	—	—
Operation and maintenance of equipment (25.7)	\$23,162,000	\$21,473,000	(\$1,689,000)
Subsistence and support of persons (25.8)	—	—	—
Subtotal, other contractual services	91,793,000	97,922,000	+6,129,000
Supplies and materials (26.0)	<u>1,720,000</u>	<u>1,724,000</u>	<u>+4,000</u>
Subtotal, Non-pay costs	102,261,000	108,316,000	+6,055,000
 Total, Salaries and Expenses	 \$218,796,000	 \$228,595,000	 +\$9,799,000

SIGNIFICANT ITEMS IN APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2003 Congressional requirements for reports and significant items derived from the FY 2003 Senate Appropriations Committee Report Language (S.Rpt 107-216). The actions discussed below are contingent on inclusion of similar language and funding in the final FY 2003 appropriation and related reports. Additional items may be transmitted at a later date as a result of the final Conference report.

Item

Preventing and Reversing Heart Disease Initiative – On May 16, 2002, the Subcommittee on Labor, Health and Human Services and Education convened a hearing to more closely examine the factors contributing to cardiovascular disease, and to explore possible approaches to prevent, control, and reverse its effects. Testimony heard from a variety of top medical experts reflected a common theme: All agreed that stress management, in conjunction with diet modification, exercise, and pharmacological and/or surgical intervention, can significantly improve the quality of life for those confronted with cardiovascular disease...For many years the National Heart, Lung and Blood Institute has supported a vigorous program of research on the behavioral and psychological impact of cardiovascular disease. Data obtained by NHLBI confirmed that mental stress could cause myocardial ischemia or reduced blood flow. Current evidence suggests that all individuals at risk for cardiovascular disease can benefit from stress reduction, but that general health and well-being are greatly improved if the first steps are taken during childhood. Among children, in fact, stress management programs have been shown to improve self-esteem, grade-point average and work habits while reducing violent behavior. To that end, the educational system in this country should be encouraged to incorporate stress management programs into school curriculum. To address the prevention and reversing heart disease initiative, the Committee has included \$419,300,000 in addition to the amounts provided as part of the physical activity and nutrition initiative. Obesity and nutrition programs work hand in hand in preventing and reducing heart disease. The Committee encourages the Departments of Health and Human Services and Education to coordinate the above programs and activities to address both initiatives.

Action Taken or to be Taken

The Secretary has implemented a new initiative, *Steps to Healthier US*, which relates to the President's *Healthier US* initiative. These initiatives focus on preventing disease by addressing major risk factors (such as physical inactivity and poor nutrition), and on reducing the burden of disease through appropriate health screenings and prevention of secondary conditions. The Secretary's initiative will have a special emphasis on diabetes, obesity, and asthma. Under *Steps to a Healthier US*, HHS will fund specific projects at

the State and local level that will use proven medical and public health strategies to reduce the burden of diabetes, obesity and asthma among their populations. The initiative includes target goals for disease reduction. Projects under the initiative include: State programs to motivate and support responsible health choices that reduce the burden of preventable disease; community initiatives to promote and enable healthful choices, especially those focused on youth and older Americans; and health care and insurance systems that put prevention first and reduce people's risk factors for chronic disease and reduce potential health care complications. The Secretary has made disease prevention and health promotion a top priority for the Department, as part of a broader effort to reduce the burden of preventable medical conditions, both in terms of lives affected and health care costs.

Item

Chronic Fatigue – The Committee is disappointed that the establishment of the Department's Chronic Fatigue Syndrome [CFS] advisory committee, announced in January 2001, has been delayed and that the advisory committee's predecessor, the Chronic Fatigue Syndrome Coordinating Committee, has not met since January 2001. These delays have jeopardized momentum and important partnerships between the member agencies and the CFS community. The Committee urges the Department to approve the CFS Advisory Committee Charter, publish a call for nominations, install members and hold one meeting, all prior to the end of calendar year 2002. It is this Committee's expectation that the new advisory committee will not diminish the full partnership of involved agencies or the collaborative relationships among Federal agencies, scientists, and CFS advocates that have developed over recent years through the CFS Coordinating Committee. The Committee anticipates that the new advisory committee will further advance the efforts of the Department and the public health service agencies to address the scientific questions about CFS and the social service needs of persons with CFS.

Action Taken or to be Taken

The Department has transformed the CFS Coordinating Committee into a fully sanctioned Advisory Committee. This Advisory Committee will be instructed to provide expert advice and recommendations to the Secretary on a broad range of issues and topics pertaining to CFS, including the development and implementation of programs to inform the public, health care professionals, and the biomedical, academic and research community about advances in understanding, treating, and preventing CFS. A new charter has been approved by the Secretary, and efforts are underway to develop a list of nominees for the Committee. These nominees will be evaluated using established criteria and final selections will be made by a review group comprised of both Federal and non-Federal members. Meetings will be held approximately twice a year.

Item

Data Collection – The Committee urges the Secretary to strengthen the Department's collection and reporting of data on health care enrollment, access and utilization by patients' race, ethnicity, primary language and socioeconomic status by all agencies engaged in, or receiving Federal funds for health-related activities. It is expected that all Federal, State, and other entities receiving Federal funds shall collect and report disaggregated data; that racial and ethnic data shall be reported by Federally-defined categories, and by subpopulation groups. Measures of racial and ethnic disparities should be used in performance measurement and in monitoring the progress of Federally-funded activities for the elimination of health disparities. As the Nation's leading health enterprise, the Department is expected to play a leadership role in assuring the collection and reporting of racial, ethnic and primary health-related data through written policy and sustained action and resources. The Secretary is urged to designate a central authority within the Department to oversee its policies in the areas, as well as dissemination, implementation and compliance activities.

Action Taken or to be Taken

HHS is a leader in the Federal government in the collection and dissemination of health data relating to race and ethnicity, and it continues to make progress in this area. Typically, programmatic initiatives to reduce or eliminate disparities in health disaggregate data according to specific minority populations. For several years, HHS has had a formal Department-wide policy requiring that all HHS-sponsored data collections include information on race and ethnicity, and collect this information in a manner consistent with the OMB standards (see the website for the HHS Data Council at <http://www.aspe.hhs.gov/datacnci>). Virtually all HHS-sponsored data collections include race and ethnicity information, and they conform to the OMB standard. Many of the major national surveys sponsored by HHS include oversamples of minority race and ethnicity groups as well. In addition, HHS is funding a study by an expert panel at the National Academy of Sciences to examine the adequacy of race and ethnicity data in HHS and other public and private sector data systems; the study will make recommendations for improvements for both the Federal and private sectors. The HHS Data Council, the internal Department-wide data policy committee within HHS, advises the Secretary on data policy issues and oversees progress on this issue.

Item

[Federal data-sets] – The Secretary must ensure that Federal data-sets meet at least the minimum standards set by the Office of Management and Budget in 1997 and subsequent standards for maintaining, collecting, and presenting Federal data on race and ethnicity. Also, the Committee reminds the Secretary of OMB's requirement that the standards be adopted as soon as possible, but not later than January 1, 2003, for use in household

surveys, administrative forms and records, and other data collections purposes.

Action Taken or to be Taken

Virtually all HHS-sponsored data collections already incorporate the OMB standard categories for race and ethnicity reporting. All of the Operating Divisions in HHS have either already converted to the revised OMB standards or have plans to complete the process in calendar year 2003, as required by the OMB guidelines.

Item

[Chronic Homelessness] – The Committee also supports efforts to address chronic homelessness more effectively through better coordination of housing and support services at both the national policy and local service delivery levels. The Committee encourages the Department to seek opportunities to partner with the Department of Housing and Urban Development [HUD] in providing service enriched supportive housing. The development of permanent supportive housing, that is, housing coupled with mental health, substance abuse and primary care supportive services, has been shown to be a highly effective model for addressing the needs of the chronically homeless. The Committee encourages Departmental program offices, including the Community Health Centers Program in HRSA, and the Centers for Mental Health Services, Substance Abuse Treatment, and Substance Abuse Prevention in SAMHSA, to work with their grantees to identify opportunities for collaborating with local housing providers to develop permanent supportive housing.

Action Taken or to be Taken

In FY 2003, HHS implemented a collaboration with HUD and the Department of Veterans Affairs (VA) to help end chronic homelessness. This collaboration has blended resources from the three Departments in a competitive grant that specifically provides service-enriched supportive housing. HHS programs SAMHSA and HRSA contributed a total of \$10,000,000 in services funding to deliver substance abuse and mental health services and primary health care to chronically homeless persons, and homeless families with a disabled adult member. The funding will engage the grantees of these programs in a community collaboration with housing providers and local veterans' health care. In addition, since FY 2002 HHS has supported technical assistance to States to encourage their development of new policy approaches to address chronic homelessness. The technical assistance is provided in Policy Academies, at which each participating State develops an action plan for integrating critical service and housing programs to address chronic homelessness, and later receives considerable support to develop and implement the action plan. HUD and VA are also collaborators with HHS in supporting these Policy Academies.

Item

[Discharge from systems of care policies and protocols] – The Committee urges the Department to study whether additional policies and protocols may be needed to ensure that persons being discharged from systems of care including mental health and substance abuse treatment programs and foster care have housing options to prevent such discharge from immediately resulting in homelessness.

Action Taken or to be Taken

In FY 2003, the office of the Assistant Secretary for Planning and Evaluation (ASPE) began assessing the contribution of discharge planning to the prevention of homelessness. The assessment examines exemplary discharge/release planning protocols in substance abuse detoxification, psychiatric inpatient, foster care, and residential treatment settings which place clients successfully in the community. The exemplary protocols will be analyzed to determine the critical components of success and for replication in other locations. Environmental factors in the community which may affect the effectiveness of discharge planning, such as service availability, job markets, and housing quality and affordability, will also be examined.

Item

Racial and Ethnic Disparities – The Committee is deeply concerned about the results of a study released in March 2002 from the Institute of Medicine [IOM], *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The Committee is committed to ensuring the overall improved health of the American people, and strongly urges the Secretary to take the steps necessary to implement the study's recommendations, which offer significant guidelines and opportunities for eliminating health disparities and improving health. Specifically, all institutes and agencies are strongly encouraged to increase the representation of racial and ethnic minorities among health professionals, advance equity of care through the use of evidence-based guidelines, and promote the concept of multi-disciplinary treatment teams and community health workers who can help patients navigate through the health care system. The Committee expects the Secretary to report on the progress of this action during next year's appropriations hearings, and to include a progress update in the Department's Budget Justification.

Action Taken or to be Taken

The Secretary has reaffirmed HHS's commitment to eliminating racial and ethnic disparities in health, and has designated the Deputy Secretary as the Departmental official to lead and advance efforts under the initiative. A milestone event was held in July 2002, the first National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health. Bringing together more than 2500 community activists, educators

and health professionals for strategy development and skills-building sessions, the event was the product of wide-scale collaboration within the Department and partnerships with other sectors, including community-based organizations.

Other specific efforts led by the Office of Minority Health which address the IOM recommendations include:

Awareness Campaign – In partnership with ABC Radio Networks, in 2002 HHS launched a national education campaign to close the health gap in African Americans. As part of this campaign, all 240 of ABC Radio's Urban Advantage Network affiliates aired detailed messages about the severity of the health problems facing African Americans, emphasizing specific steps listeners can take to adopt healthier lifestyles. The campaign also included "Take a Loved One to the Doctor Day," an effort designed to encourage improved health screening for minority Americans. "Take a Loved One to the Doctor Day" was held September 24, 2002, and included more than 400 national, State, and community-based partners. In addition, more than 200 communities in 47 States, DC, and Puerto Rico convened health activities on this day. OMH plans similar events for FY 2003 and FY 2004, in partnership with State, local, non-profit, private and community groups; OMH also intends to expand outreach to Hispanic and other racial and ethnic minority communities. HHS also seeks to continue expanding private sector, corporate and foundation involvement in the campaign.

Small Population Group Data – The IOM study recommendations stressed the necessity of reporting health data by OMB categories and using sub-population data where possible. The ability to collect and monitor health-related data by race and ethnicity is critical to identifying the nature and extent of racial or ethnic disparities in health/health care, and to monitoring progress towards the elimination of such disparities. Data collection is further complicated with respect to smaller and hard-to-reach minority groups, for which there is a persistent lack of data. Current data collection methods fail to provide sufficient data on racial and ethnic minority sub-populations such as homeless and migrant workers. In FY 2003, OMH has proposed an evaluation study to conduct a systematic review, interpretation, and synthesis of the research literature on new, existing, and modified methods of data collection/analysis for racial and ethnic minorities. The project will entail development of a cost-effective and statistically reliable approach to developing estimates of prevalence of various health behaviors, risk factors, and outcomes in small racial and ethnic groups. The approach will be tested for validity and evaluated for limitations and conditions under which the propose approach is best used.

Assessing the Impact of Physician-Patient Communication Barriers on the Cost and Quality of Health Care – The IOM study "Unequal Treatment" recommended research on sources of health care disparities and promising intervention strategies to eliminate disparities in quality by race and ethnicity. In FY 2003, OMH plans to launch a study to

better understand the relationship between communication barriers and health care quality, which will include: developing a classification of medical errors associated with communication barriers; designing a preliminary framework for identifying associated direct and indirect costs and/or impacts on clinical outcomes. The project will focus on verbal communications during clinical encounters between physicians and patients who speak different languages.

Item

[New prevention projects] – Within the total provided, the Committee continues the prevention projects begun in fiscal year 1998, as well as new prevention projects. The Committee again expects the Department to fund new prevention projects which enable smaller communities to begin the organization and implementation of coalitions to implement abstinence-based education programs. The Committee again expects the Department, when announcing grant competitions, to provide a reasonable length of time for applicants to complete application packages, provide extensive technical assistance to applicants, with special assistance given to new applicants, and revise the terminology and instructions in grant applications to assure that the information being requested is as clear as possible.

Action Taken or to be Taken

The Office of Population Affairs (OPA) administers the Adolescent Family Life (AFL) program. OPA will allocate approximately \$12.8 million to fund continuing and new abstinence-based prevention projects. These projects are community-based and community-supported organizations with a focus on providing and expanding adolescent abstinence-based educations. OPA will continue its efforts on providing technical assistance to grants applicants and continue its work on extending the length of time for grant applications up to 60 days. To the extent feasible and legal, the program will revise the grant application instructions and terminology in an effort to make the information clear and concise.

Item

[Physical activity and nutrition initiative] – The Committee has provided additional resources in this bill for a physical activity and nutrition initiative. The President's Council is urged to take a look at the Committee's recommendations and offer suggestions regarding how to coordinate between programs receiving funds for this purpose and how to build upon this initiative next year.

Action Taken or to be Taken

The mission of the President's Council on Physical Fitness and Sports is to make

recommendations to the Secretary on issues related to physical activity, fitness and sports, and to recommend programs to promote regular physical activity for the health of the nation. The current Council was sworn into office on June 20, 2002. At their June 2002 meeting, the reinvigorated Council acknowledged joining their “tremendous ideas and vast web of contacts, resources, skills, and abilities” with CDC, the Department of Education, and the private sector to benefit the Nation. The Council will be spreading the President’s *Healthier US* message, and is making recommendations and suggestions to enhance the Nation’s participation in physical activity.

Item

[Recruit and train minorities in health professions] – The Committee continues to recognize the need to recruit and train more minorities in the health professions. The Committee encourages the Office of Minority Health [OMH] to support established programs that have a proven record of increasing the number of under-represented minorities entering the health professions.

Action Taken or to be Taken

Ensuring diversity in the health professions has been a cross-cutting priority for OMH since its creation in 1986. Working in collaboration with both HHS leadership and the OPDIVs and STAFFDIVs, OMH continues to formulate policy and coordinate program efforts to address the under-representation of racial and ethnic minorities in the health professions. Specific OMH-led efforts include:

Internship, Youth Initiative, and Faculty Development Projects – OMH is supporting projects on health professions development through cooperative agreements with national organizations which represent minority institutions of higher education and health professions organizations. For example, the American Indian Higher Education Consortium, Hispanic Association of Colleges and Universities, and the National Association of Equal Opportunity in Higher Education conduct projects to enhance the awareness of minority undergraduate and graduate students to health professions training programs and career opportunities. Minority students from across the Nation are recruited to serve in intern positions, and receive individual career building experiences. Youth Initiative projects are carried out by the Auxiliary to the National Medical Association, Association of American Indian Physicians, and Interamerican College of Physicians and Surgeons. These projects bring together minority students with expressed interest in health careers to increase their knowledge of career opportunities and to meet national level policy makers. The Harvard Medical School/Minority Faculty Development Program, Hispanic Serving-Health Professions Schools, National Hispanic Medical Association, and Quality Education for Minorities Network are carrying out projects which support minority faculty and medical professionals development in areas relating to health disparities and minority health.

Evaluating the Success of College/University-Based Mentoring and Other Health Professions Development Programs in Recruiting Minorities into the Health Professions - Building a health professions' workforce that reflects the diversity of the Nation depends, at least in part, on the effectiveness of "pipeline" efforts to attract, train, and retrain racial and ethnic minorities into clinical, public health, and biomedical research fields. However, the nature and extent of existing workforce "pipeline" strategies and interventions (including mentorship programs) is not well understood. In FY 2003, OMH plans to undertake an evaluation project which will review studies done on the relative successes or impacts of public health/health care workforce "pipeline" strategies and interventions, with a particular focus on mentoring programs, and conduct a study to assess the effectiveness of mentoring programs and other workforce "pipeline" efforts in promoting pursuit of careers in the health professions by racial and ethnic minorities. OMH will collaborate with HRSA's Bureau of Health Professions, CDC's Public Health Practice Program Office, and other HHS and non-HHS entities in this effort.

Item

Health Disparities - The Committee commends the Secretary for designating the elimination of health disparities as a major priority for the Department, and is encouraged that the agencies within the Department are moving forward in this area as they develop, implement, and evaluate strategic plans for eliminating health disparities. The Committee expects the Office of Minority Health [OMH], along with the National Center for Minority Health and Health Disparities at the National Institutes of Health, to coordinate and monitor the implementation of the Department's elimination of health disparities strategic plans. The Committee expects the Secretary to report to Congress on the progress and implementation of the strategic plans during next year's appropriations hearings, and to include a progress update in the Department's Budget Justification.

Action Taken or to be Taken

OMH has established the Departmental Minority Health Steering Committee (DMHSC), which held its first meeting on January 23, 2003. The DMHSC is comprised of key officials from within HHS, including heads of agency-level offices of minority health and individuals designated responsible for eliminating health disparities programs and initiatives. The DMHSC serves as an advisory body for the implementation and monitoring of the HHS Initiative for Closing the Health Gap, and provides policy direction and guidance for four minority health initiatives governed by Presidential executive orders.

Another example of how OMH is able to coordinate activities across both HHS and the entire Federal sector is the Interagency Task Force on Environmental Justice and Health Disparities. Together with the Environmental Protection Agency, OMH is providing leadership to the Task Force. The purpose of the Task Force is to bring together Federal

agencies with environmental justice and health disparities missions, to develop a coordinated approach for eliminating health disparities and achieving environmental justice for racial and ethnic minorities. A symposium is planned for Spring 2003 to begin discussions among Federal agencies, and to devise strategies for coordination regarding environmental justice and health disparities activities.

Item

[Office on Women's Health] – The Committee remains strongly supportive of the work done by the Office on Women's Health [OWH] in the Office of the Secretary. In addition to its own work advancing women's health, it provides critical coordinating services with offices located in NIH, CDC, HRSA, FDA, SAMHSA, AHRQ, and CMS. In totality, these offices assure that issues related to research, treatment, services, training, and education efforts by HHS reflect the distinct needs of women. The Secretary should notify the Committee in advance of any changes planned for the status, location, or reporting structure of this office or any of the offices enumerated above.

Action Taken or to be Taken

HHS plans no action with regard to the position, leadership, or staffing in either OWH or the women's health offices located in NIH, CDC, HRSA, FDA, SAMHSA, AHRQ, or CMS. The Secretary will notify the Committee in advance of any significant changes in the status of any of these offices.

Item

[Health Alert Network] – The Committee provides \$940,000,000 to CDC for upgrading State and local capacity. This amount maintains funding at the level provided last year. The Committee has included \$40,000,000 for the Health Alert Network [HAN]. The Health Alert Network was established to provide ongoing communications, technology, information systems support and education and training to local public health agencies. The Committee recognizes the important role that HAN played during and after the events of September 11. The Committee is also aware that the broad public health infrastructure required is the same for bioterrorism preparedness as for other public health threats. The Committee also recognizes that ongoing support for communications, technology and information systems is necessary to ensure that broad-based public health capacity is improved and maintained. Given the investment made in the development of HAN, the Committee expects that CDC will move forward with the next logical phase of the network, which is to provide workforce training and education, support for organizational capacity building in local public health agencies and the creation of knowledge management systems required by public health practitioners.

Action Taken or to be Taken

This item has been assigned to the Centers for Disease Control and Prevention (CDC). Please refer to the Significant Items section in the Congressional Justification for CDC.

AUTHORIZING LEGISLATION

	2003 Amount <u>Authorized</u>	2003 <u>Pres Budget</u>	2004 Amount <u>Authorized</u>	2004 Budget <u>Request</u>
General Departmental Management, except accounts below:				
Reorganization Plan No. 1 of 1953	Indefinite	\$208,866,000	Indefinite	\$214,767,000
Office of Public Health and Science:				
Public Health Service Act,				
Title III, Section 301	Indefinite	49,132,000	Indefinite	53,313,000
Title XVII, Section 1701 (ODPHP)	Indefinite	7,589,000	Indefinite	7,620,000
Title XVII, Section 1707 (OMH)	Indefinite	46,329,000	Indefinite	47,010,000
Title XX, Section 2010 (AFL) ¹		<u>31,124,000</u>	¹	<u>31,241,000</u>
Subtotal		134,174,000		139,184,000
Total appropriation		\$343,040,000		\$353,951,000

¹ Authorization for Section 2010 of PHS Act Title XX expired September 30, 1985. Reauthorization will be proposed.

APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
<u>FY 1995</u>				
Appropriation	\$93,351,000	\$89,500,000	\$88,774,000	\$91,247,000
Rescissions	-	-	-	-1,214,000
SSA Transfer	-2,722,000	-	-	-1,361,000
Trust Funds	32,161,000	31,008,000	31,008,000	31,008,000
Rescissions	-	-	-	-332,000
SSA Transfer	-23,397,000	-	-	-11,699,000
<u>FY 1996</u>				
Appropriation	86,162,000	136,499,000	130,499,000	139,499,000
Rescission	-	-	-	-544,000
Trust Funds	7,204,000	6,628,000	6,628,000	6,628,000
Rescission	-	-	-	-25,000
<u>FY 1997</u>				
Appropriation	141,938,000	148,999,000	153,837,000	174,523,000
Rescission	-	-	-	-320,000
Trust Funds	9,187,000	5,851,000	5,851,000	5,851,000
<u>FY 1998</u>				
Appropriation	166,326,000	159,636,000	174,588,000	171,631,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
<u>FY 1999</u>				
Appropriation	154,092,000	166,662,000	168,309,000	189,051,000
Rescission	-	-	-	-341,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
<u>FY 2000</u>				
Appropriation	185,561,000	171,936,000	193,203,000	207,051,000
Rescission	-	-	-	-1,478,000
Trust Funds	6,851,000	5,851,000	6,517,000	5,851,000

APPROPRIATIONS HISTORY TABLE
(Cont.)

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
<u>FY 2001</u>				
Appropriation	\$223,741,000	\$206,780,000	\$204,266,000	\$285,224,000
Rescission	-	-	-	-438,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
<u>FY 2002</u>				
Appropriation	415,348,000	333,036,000	416,361,000	341,703,000
Rescissions	-	-	-	-2,167,000
Trust Funds	5,851,000	5,851,000	5,851,000	5,851,000
<u>FY 2003</u>				
Appropriation	387,880,000			
Trust Funds	5,851,000			
<u>FY 2004</u>				
Appropriation	348,100,000			
Trust Funds	5,851,000			

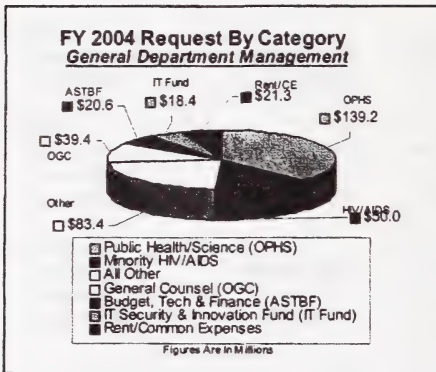
GENERAL DEPARTMENTAL MANAGEMENT

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$333,303,000	\$343,040,000	\$353,951,000	+\$10,911,000
FTE	1,332	1,417	1,406	-11

GENERAL STATEMENT

The FY 2004 budget request for General Departmental Management (GDM) includes \$353,951,000 in appropriated funds and 1,406 full-time equivalent (FTE) positions. This request is \$10,911,000, or 3.2 percent, above the comparable FY 2003 President's Budget request.

The GDM appropriation supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department in administering and overseeing the organization, programs, and activities of the Department. These activities are carried out through 12 Staff Divisions (STAFFDIVs), including: the Immediate Office of the Secretary, the Departmental Appeals Board, and the following Offices: Administration and Management; Budget, Technology and Finance; Disability; General Counsel; Global Health Affairs; Intergovernmental Affairs; Legislation; Planning and Evaluation; Public Affairs; and Public Health and Science. (NOTE: Public Health Emergency Preparedness is funded from the Public Health and Social Services Emergency Fund; see the PHSSEF section of this Justification.)



The Office of Public Health and Science (OPHS) – the largest GDM STAFFDIV – serves as the focal point for leadership and coordination across the Department in public health and science, and provides advice and counsel to the Secretary on public health and science issues. OPHS also exercises management responsibility for nine cross-cutting program offices, including: Surgeon General, HIV/AIDS Policy, Adolescent Family Life, Disease Prevention and Health Promotion, President's Council on Physical Fitness and Sports, Minority Health, Women's Health, Human Research Protections, and Research Integrity.

This justification includes narrative sections describing the activities of each STAFFDIV funded under the GDM account, plus the Rent and Common Expenses accounts. (Resource tables reflect only funding provided from the GDM appropriation. FTE figures include full-time, part-time, and temporary employees.) This justification also includes selected performance information, as required by the Government Performance and Results Act (GPRA). Performance objectives and measures for activities in ASPE, ASBTF, ASAM, OPHS and the Departmental Appeals Board are located at the "DM GPRA Performance Plans" tab.

Non-comparable appropriated funding for GDM during the last five years, including amounts available for obligation from both general funds and trust fund transfers, has been as follows:

<u>Fiscal Year</u>	<u>Funds</u>	<u>FTE</u>
1999	\$194,061,000	1,245
2000	\$224,165,000	1,329
2001	\$309,635,000	1,341
2002	\$345,887,000	1,453
2003	\$343,040,000	1,417

In addition to appropriated funds, the GDM budget uses other sources and types of funding, including inter-departmental delegations of authority, inter-agency reimbursements, and funds from the Health Care Fraud and Abuse Control (HCFAC) account. GDM also conducts centrally-managed projects which benefit the Department's Operating Divisions (OPDIVs) and STAFFDIVs under the authority of the Economy Act (31 USC 1535) or other specific statutes. Costs for these activities are distributed among the OPDIVs and STAFFDIVs on a proportional basis, using an established cost distribution formula.

The FY 2004 budget request supports the **President's Management Agenda** and reflects cost savings from: consolidating administrative functions; organizational layering to speed decision-making processes; competitive sourcing; implementation of effective workforce planning and human capital management strategies; and adoption of other economies and efficiencies in administrative operations.

The GDM FY 2004 budget request also reflects **Information Technology (IT)** savings which will be realized from on-going IT consolidation efforts, and additional spending reductions made possible through the streamlining or elimination of lower-priority projects. GDM is participating in the consolidation of IT infrastructure support staff services across the eight smaller OPDIVs. The implementation of this consolidation by October 2003 will further reduce infrastructure expenditures for several OPDIVs.

Finally, HHS is implementing a **Unified Financial Management System (UFMS)** to replace five legacy accounting systems currently used across the OPDIVs. The UFMS will integrate the Department's financial management structure, and provide HHS leaders with a more timely and

coordinated view of critical financial management information, including more accurate assessments of the cost of HHS programs. It will also promote the consolidation of accounting operations, and thereby substantially reduce the cost of providing accounting services throughout HHS. Similarly, by generating timely, reliable and consistent financial information, UFMS will enable OPDIV Heads and program administrators to make more timely and informed decisions regarding their operations. GDM requests a total of \$1,793,000 to support this effort in FY 2004.

IMMEDIATE OFFICE OF THE SECRETARY

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$7,587,000	\$7,999,000	\$8,235,000	+\$236,000
FTE	69	69	68	-1

Purpose and Method of Operations

The Immediate Office of the Secretary (IOS) provides leadership, direction, policy, and management guidance to the Department, and support for the Secretary and Deputy Secretary in their roles as representatives of both the Administration and HHS. IOS serves as the nucleus for HHS activities. Responsibilities associated with policies and issues that the Secretary and HHS must confront daily include more than 300 programs, covering a wide spectrum of activities. Some of these issues include: health care quality; biomedical research; food and drug safety; reducing the use of tobacco products; Medicare; Medicaid; HIV/AIDS; women's health; domestic violence; public health; Head Start; teen pregnancy; youth substance abuse; and many other critical Federal responsibilities.

The major objectives of IOS in FY 2004 will be to:

- Provide advisory assistance and executive level staff support essential for the Secretary to manage and direct the myriad programs mandated to the Department.
- Coordinate all Departmental documents, issues and regulations requiring Secretarial action; mediate the resolution of differences between Departmental components; communicate Secretarial decisions; and ensure the implementation of those decisions.
- Provide assistance, direction and coordination to the White House and other Cabinet agencies on HHS issues.
- Oversee the operations and functions of IOS entities: Scheduling and Advance, the Executive Secretariat, Global Health Affairs, and the White House Liaison.
- Set the Department's regulatory agenda and review all new regulations and regulatory changes to be issued by the Secretary; perform an on-going review of regulations which have already been published, with particular emphasis on reducing the regulatory burden.
- Review, validate and revise HHS initiatives and support for Global Health activities.

- Increase the efficiency and cost-effectiveness of the Department through improved management of resources and operations. Evaluate the potential for cost savings through the introduction of a centralized approach to developing, operating and maintaining automated administrative systems.

Rationale for the Budget Request

The FY 2004 request for IOS is \$8,235,000, a net increase of \$236,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$3,751,000	\$4,064,000	\$4,155,000	+\$91,000
FTE	33	35	34	-1

Purpose and Method of Operations

The Office of the Assistant Secretary for Public Affairs (ASPA) serves as the principal public affairs officer in all aspects of Departmental policy and activities; oversees the planning, management and execution of communication activities throughout HHS; conducts Department-wide public affairs programs; provides public information and support on legislative initiatives which cut across program and Operating Division lines within the Department; establishes and administers the Freedom of Information Act (FOIA) and Privacy Act Department-wide; and provides information on Departmental actions and purposes to the general public.

ASPA's major objectives in FY 2004 will be to:

- Focus on communicating improvements to the healthcare system in America.
- Strengthen and enhance communication infrastructure and preparedness for emergencies, particularly bioterrorism.
- Continue health promotion and disease prevention public awareness programs – with an emphasis on minority and disadvantaged audiences – through the coordination of interviews, press conferences, op/eds, letters to the editor, and public service announcements.
- Establish a Web Portal Office to maintain, upgrade, and enhance the Department's website.
- Provide important health information to the public through video and audio news releases, satellite interviews with HHS spokespersons, and printed materials.
- Review Departmental requests for clearance of publication and audio-visual material, with the goal of eliminating wasteful spending, improving communications to the public, and finding more strategic and cost-effective means of providing information.
- Strengthen communication with the public on vital health issues.

- Improve the effectiveness of the multitude of education and marketing campaigns that take place throughout the Department, beginning with stronger coordination among agencies and better front-end planning and execution.
- Strengthen communication capabilities for public health crises, including bioterrorism and infectious disease outbreaks.
- Provide OpEd and other materials on a regular basis to national and regional media, including minority media, with special emphasis on preventive health care messages, personal responsibility and the importance of the family.
- Improve outreach to the Hispanic media market, providing important health messages to the Hispanic community through Spanish-language materials, such as audio news releases, television interviews, and Spanish-language stories on HHS Radio.
- Continue the production of speeches, statements, articles, editorials, video scripts and other written materials for Departmental officials.
- Continue technical support and maintenance of the FOIA tracking system as well as processing increasingly complex FOIA requests.
- Maintain the system for clearance and issuance of press releases, streamlining the process where possible.
- Expand production and distribution of health messages to television and radio broadcasters, with a special emphasis on reaching disadvantaged and minority populations.
- Produce satellite news conferences and media tours that bring health information directly to English and Spanish-speaking TV affiliates around the country.

Rationale for the Budget Request

The FY 2004 request for ASPA is \$4,155,000, a net increase of \$91,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

ASSISTANT SECRETARY FOR LEGISLATION

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$2,877,000	\$3,161,000	\$3,244,000	+\$83,000
FTE	26	28	28	-

Purpose and Method of Operations

The Office of the Assistant Secretary for Legislation (ASL) serves as the principal advisor before Congress for the Administration's health and human services initiatives; serves as chief HHS legislative liaison and principal advisor to the Secretary and the Department on Congressional activities; and maintains communications with executive officials of the White House, OMB, other Executive Branch departments, members of Congress and their staffs, non-governmental organizations and associations, and selected legislative programs.

ASL's responsibilities include advising the Secretary on all policy matters relating to HHS legislation; serving as an information resource for members of Congress and staff on HHS programs, grants and initiatives; providing guidance on the development and analysis of Departmental legislation and policy, including formulation of the budget; directing and coordinating legislative initiatives to ensure consistent and strong advocacy before Congress; and securing Congressional enactment of program and policy reform proposals.

ASL's major objectives in FY 2004 will be to:

- Present the Administration's health and human services legislative agenda before the Congress. This includes analysis and resolution of issues raised by Members of Congress and Congressional staff during consideration of HHS authorizing and appropriations legislation.
- Provide quality service and information to Members of Congress and staff concerning HHS programs, grants, and initiatives.
- Manage the Department's legislative agenda, including the introduction of legislative initiatives within the jurisdiction of HHS.
- Coordinate Departmental participation in Congressional hearings, mark-ups and conference committee meetings. This includes arranging briefing sessions, identifying witnesses, supervising, drafting, and clearing testimony and position papers, communicating the Administration's positions to the Congress, and advising Department

officials of the results of Congressional action.

- Develop and execute Departmental legislative and regulatory activities by providing more effective guidance to, and increasing participation with, other Executive Branch officials and the Department's OPDIVs and STAFFDIVs.
- Standardize all operations of ASL's Office of Legislation, in order to ensure timely, quality information is provided to the Secretary, other Executive Branch departments, and Capitol Hill.
- Implement and fully utilize a new inter-departmental legislative communications network.

Rationale for the Budget Request

The FY 2004 request for ASL is \$3,244,000, a net increase of \$83,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$6,511,000	\$6,993,000	\$7,019,000	+\$26,000
FTE	79	95	95	-

Purpose and Method of Operations

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides policy analysis and advice; guides the formulation of legislation; coordinates strategic and implementation planning; conducts regulatory analysis and reviews regulations; oversees the planning of evaluation, non-biomedical research, and major statistical activities; and administers evaluation, data collection, and research projects and oversight to assure information needed for HHS policy development.

These functions can be grouped into two components: planning and policy analysis and development, and policy management and support. Most ASPE resources are used for policy analysis and development; the remainder is used to provide policy support in the form of executive direction, administration, planning and monitoring of activities to achieve the Department's goals and objectives, oversight of evaluation, and coordination of Departmental data policy and services, including simulation modeling, programming, and technical assistance.

The major accomplishments planned for ASPE in FY 2004 are as follows:

- Conduct planning and policy analysis to support the President and Secretary's major program initiatives, including analysis that anticipate the impact of major demographic, social and scientific changes on the nation and HHS programs.
- Manage the development, coordination and the implementation of the Department's strategic plan.
- Maintain and enhance micro-simulation models to support both the implementation of these major initiatives and the development of other initiatives. Use these models to identify the costs and effects of various policy proposals.
- Formulate and coordinate HHS-wide data policy, including data collection strategy, data standards, and policy, to address current and emerging data needs related to the impact of new public policy proposals.

- Conduct short-term analyses and provide day-to-day analytic and technical support for policy formulation for the Secretary and other senior officials.
- Provide policy-relevant information on national trends in public and private health and human services activities, and the populations affected by HHS programs and policies.
- Complete the development of the Department's FY 2004 legislative program, resulting in the submission of bills and proposals to Congress. Prepare justification materials for Congressional committees and manage the development of the Department's legislative program for FY 2005.
- Coordinate the Department's planning of high priority regulations, and review all regulations for policy, economic, Federalism and family impact.
- Coordinate the development and implementation of policies to make services more accessible, comprehensive, and integrated.
- Provide information to States, local communities, researchers and others for consideration as new health and human services strategies are designed, tested and implemented.
- Work with the OPDIVs in collaborative efforts to implement various recommendations to improve data collection and analysis. For example, working through the Data Council, ASPE will collaborate with the National Center for Health Statistics, the Agency for Healthcare Research and Quality, and other agencies in refining national surveys and in developing new capabilities for obtaining data to assess the changes in health and human services, and the well-being of individuals at the State and local level.
- In addition, in FY 2003 and FY 2004 ASPE plans to pursue evaluations to support program performance information needs identified by the Performance Assessment Rating Tool (PART) analysis for several programs, including CDC Childhood Immunizations, HRSA Nursing Loan Repayment, Brief Intervention under the President's Drug Treatment Initiative, and IHS Sanitation Facilities.

To address the President's management agenda, ASPE has focused on organizational consolidation and eliminating management layers. In this respect, ASPE has eliminated one major office through consolidation and has eliminated a number of unnecessary supervisory positions. Additionally, ASPE has improved its administration of grants by developing a partnership agreement with National Institute of Child Health and Human Development (NICHD) to use their grant expertise and electronic technology. ASPE currently outsources much of its research and evaluation studies.

Rationale for the Budget Request

The FY 2004 request for ASPE is \$7,019,000, a net increase of \$26,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

ASSISTANT SECRETARY FOR BUDGET, TECHNOLOGY AND FINANCE

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$19,218,000	\$20,117,000	\$20,588,000	+\$471,000
FTE	129	144	148	+4
HCFAC account ¹	[\$125,000]	[\$-]	[\$-]	[\$-]
HCFAC FTE	[-]	[-]	[-]	[-]

Purpose and Method of Operations

The Office of the Assistant Secretary for Budget, Technology and Finance (ASBTF) advises the Secretary on all aspects of budget, financial management and information technology, and provides for the direction of these activities throughout the Department. ASBTF's responsibilities involve a number of functions which have been consolidated into three major areas: Budget Services, Financial Services, and Information Resources Management Services. Each of these areas is described in detail below and on the following pages.

- Budget Services – Manages the preparation of the Department's annual budget, and prepares the Secretary to present and defend the budget to the public, the media, and Congressional committees. Prepares analyses, options, and recommendations on all budget and management issues related to the Secretary's review of budget submissions from the OPDIVs, the Secretary's request to the President, and the President's submission to Congress on behalf of HHS. Analyzes regulations and policies for financial implications. Manages and directs implementation of the requirements of major financial management legislation including the Anti-Deficiency Act. Serves as Departmental liaison with central agencies on budget execution. Provides support to program and financial managers for implementation of the Government Performance and Results Act (GPRA). Incorporates performance measurement information into the HHS budget.
- Financial Services – Advises the Secretary on all aspects of financial management, and directs, coordinates and provides support for all financial management activities across the Department. Provides leadership to OPDIV senior financial managers, including the OPDIV Chief Financial Officers (CFO), through the CFO Council. Manages and directs implementation of the requirements of major financial management legislation including:

¹ Funding for the Health Care Fraud and Abuse Control (HCFAC) program is appropriated separately and is a non-add to GDM.

the CFO Act and the Government Management Reform Act (GMRA); the Anti-Deficiency Act; the Debt Collection Improvement Act (DCIA); the Federal Managers Financial Integrity Act (FMFIA); the Federal Financial Management Improvement Act (FFMIA); and the Travel and Transportation Reform Act of 1998. Develops Department-wide financial management policies and standards in conformance with the Federal Accounting Standards Advisory Board (FASAB) government-wide accounting concepts and standards. Serves as Departmental liaison with central agencies on financial matters. For the cost policy function, oversees the OPDIVs and coordinates with OMB and other central agencies as well as the HHS regional Divisions of Cost Allocation on cost issues related to recipients of Federal financial assistance under HHS programs including State and local governments, colleges and universities and other non-profits.

- Information Resources Management (IRM) Services – Provides assistance and guidance on the use of information technology (IT)-supported business process re-engineering, investment analysis, performance measurement, strategic planning, and development and application of information systems and infrastructure. Coordinates the HHS IT Budget data collection, analyses and presentation. Manages and maintains requirements under the Paperwork Reduction Act and the Clinger-Cohen Act as defined in OMB Circular A-130. Provides liaison with OMB and other Federal Departments, as well as internal coordination in connection with the fulfillment of the President's Management Plan objective relating to citizen-centered government. Develops policies to provide improved management of information resources and technology, and to provide better, more efficient service to HHS clients and employees.

The FY 2004 budget will allow ASBTF to carry out the following major goals and objectives:

Budget Services

- Plan and coordinate all HHS events for the Departmental budget, including reviewing OPDIV requests, developing alternative recommendations, and ensuring timely submission to the President and the Congress. Continue such efforts throughout all upcoming budget processes.
- Provide the Secretary with all budget-related materials and information necessary for presentation to any audience. This involves ensuring the Secretary's success in budget presentations in support of the programs of the President. Continue such efforts throughout all upcoming budget processes.
- Successfully manage the major workloads required in support of the annual budget submissions and other program budget analyses and estimates which occur throughout the year. Continue such efforts throughout all upcoming budget processes.

- Manage, provide guidance and direct assistance in implementing the President's Management agenda, especially budget and performance integration; review annual performance plans required by GPRA and incorporate performance measurement information into the HHS budget. Continue to provide such guidance and assistance throughout all upcoming budget processes.
- Prepare the annual HHS Performance Plan.
- Assist CMS and ACF with financial issues related to the Department's "mandatory" funding programs, which includes review and analysis of regulations and policies. Continue to provide such assistance throughout all upcoming budget processes.
- Increase outreach to customers through briefings, Internet web pages, and video training programs, and printed and electronic information. Continue such efforts throughout all upcoming budget processes.
- Assure HHS' compliance with the requirements of the Anti-Deficiency Act, especially regarding the apportionment of HHS accounts.
- Maintain the Financial Information Reporting System (FIRS), which provides summary financial information in a central database that is used to develop outlay estimates for the President's Budget. It also provides a tracking system for all HHS apportionments.
- Provide Department-wide direction for financial management of the Service and Supply Fund (SSF), and manage the policies set by the SSF Board of Directors. Continue to provide such direction and guidance throughout all upcoming budget processes.
- Manage the requirements for the Paperwork Reduction Act in the Office of the Secretary.

Financial Services

- Prepare timely financial statements as required by the CFO Act as amended by GMRA. In support of the President's Management Agenda to accelerate financial statement reporting, begin preparation for the November 15, 2004 deadline by pilot testing the FY 2003 financial statements for submission to OMB by November 15, 2003 – more than 75 days earlier than for the FY 2002 financial statements, which were not required until January 31, 2003.
- Manage the preparation of the Department's annual Performance and Accountability Report (PAR) under the Reports Consolidation Act of 2000.
- In support of the President's Management Agenda, continue implementation of the Unified Financial Management System (UFMS), which will replace the five legacy

accounting systems currently used across the Department. The Program Management Office (PMO) which directs the implementation of UFMS, is located in Financial Services. HHS is requesting a total of \$49.9 million Department-wide to support the UFMS effort in FY 2004.

- Work with the OPDIVs to develop and implement plans related to erroneous payment rates initiated under the President's Management Agenda and the new requirements of the Improper Payment Act.
- Continue efforts to increase collections under the DCIA by 10 percent in FY 2003 and FY 2004.
- Streamline the Departmental financial reporting process, utilizing expertise from the private sector.
- Strengthen financial accountability by including improving financial performance in annual performance contracts for each OPDIV Head.
- Audit resolution results for FY 2003 and FY 2004 are expected to exceed both prior year results and targets for current years. The FY 2004 target reflects a 2.5 percent decrease from FY 2003 in the number of days needed to complete assigned audits.

Information Resources Management Services

- Support the realization of the Secretary's "One HHS" vision by aligning the Office of Information Resources Management's (OIRM) organizational structure and goals, to bring all HHS OPDIVs together in terms of IT. Facilitate development of the Department's Five-Year IT Strategic Plan. Promote the integration and consolidation of IT assets and related resources, to capitalize on economies of scale. Promote best business practices and standardization where they are beneficial to HHS.
- Electronic government (e-Gov) is one of five key elements in the President's Management Agenda. The President has outlined how his e-Gov initiative will focus on reforming the Federal government so that it is citizen-centered. OIRM is providing the leadership and advocacy for HHS's Department-wide coordination of this initiative. Our e-Gov vision is to employ Information Technologies in concert with the Department's Strategic Plan, and help create a "One HHS" that looks at our programs from a citizen's perspective and closes the performance gap by providing seamless and integrated services to constituents. The "One HHS" program fulfills the ultimate vision of e-Gov, to create a virtual pool of government information and services available from throughout HHS and accessible by all citizens. All levels of HHS will collaborate as equal partners to provide citizen-centric services. The OIRM e-Gov mission is to establish, support, and maintain a Departmental e-Gov program that coordinates and

makes visible current and future efforts between the HHS OPDIVs and Federal, State, and local governments, business entities, and the public, as well as act to improve internal efficiencies and effectiveness.

- Develop and communicate policies and guidelines to establish IT capital planning and investment control and security improvements, consistent with the President's Management Agenda, OMB Circular A-11, and other pertinent directives.
- Continue initiatives for enterprise-wide improvements to HHS's network infrastructure, and to consolidate common business systems. Provide oversight for the design, development, and implementation of enterprise systems, such as the UFMS and the Enterprise Human Resource and Payroll (EHRP) system.
- Establish initiatives to improve capabilities while optimizing associated costs of HHS communications. Represent HHS's interests on government-wide committees and councils, including the Interagency Management Council (IMC) and the FTS Executive Steering Committee.
- Continue to lead disaster recovery efforts and provide Departmental leadership and policy for HHS with regard to Telecommunications. The OIRM Telecommunications Manager: acts as agency coordinator for all FTS telecommunications matters and shares this information throughout the Department; works with the Department's local and long-distance carriers and contract providers to meet HHS requirements; directs transitions from expiring to replacement contracts (such as FTS2000 to FTS2001); and acts as the Departmental representative in such matters. Another transition is in the planning stages, to commence in 2004.
- Provide leadership and oversight in the design and implementation of infrastructure upgrades necessary to improve IT security in HHS.
- Negotiate and initially manage enterprise-wide IT software license contracts. Lead the Department in enterprise-wide IT equipment, as well as services procurement offering deep discounts to all OPDIVs. Institutionalize these efforts with the appropriate HHS Acquisition Management Office, to create an HHS Enterprise IT Procurement Center.
- Coordinate with the Office of Budget for the IT Capital Asset Planning data required by OMB Circular A-11 and related directives.
- Through leadership and pro-active involvement, facilitate improvements in change management initiatives, to improve Departmental compliance in IT-related mandates, including: GPRA; Paperwork Reduction Act (PRA); Government Paperwork Elimination Act (GPEA); Section 508 of the American Disabilities Act (ADA); Government Information Security and Reform Act (GISRA); OMB Circulars A-11, A-76

and A-130; and other pertinent laws, regulations and directives. Champion enterprise attention to these important matters.

Rationale for the Budget Request

The FY 2004 request for ASBTF is \$20,588,000, a net increase of \$471,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

ASSISTANT SECRETARY FOR ADMINISTRATION AND MANAGEMENT

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$15,881,000	\$16,696,000	\$17,100,000	+\$404,000
FTE	131	156	150	-6

Purpose and Method of Operations

The Assistant Secretary for Administration and Management (ASAM) serves as the OPDIV Head for the Office of the Secretary. The duties and responsibilities of the ASAM include: advising the Secretary on all aspects of administration; providing leadership; policy guidance, supervision, and coordination of long and short-range planning for the Department; and ensuring that HHS meets the goals set forth for it in the President's Management Agenda.

The offices in ASAM perform the following duties:

- Grants and Acquisition Management – Provides policy direction and technical assistance in the areas of grants management, acquisition, logistics, real property security and environmental policy. Develops Department-wide grants, acquisition and logistics policies. Conducts projects to pursue innovation and improvement in the management of the Department's procurement, grants logistics operations, and real property security and environmental policy. Manages the Department's Small and Disadvantaged Business Utilization Program.
- Human Resources – Provides leadership in the development and assessment of the Department's human resources programs and policies. Designs human resource programs and strategies that support and enhance the HHS mission and the objectives of the President's Management Agenda. On behalf of the Department's Director of Equal Employment Opportunity, adjudicates complaints of discrimination. Serves as Department liaison to central management agencies exercising jurisdiction over personnel and EEO matters.
- Facilities Management and Policy - The *Division of Facilities Management (DFM)* provides, plans and directs the total physical facilities program for the Department, which includes facilities master planning, design, construction, operations and maintenance of all buildings, and property management of leased space and facilities, including space management. DFM also provides ongoing administrative and operations support to the Department's Capital Asset Planning Board, and is a major player in HHS-wide business continuity and contingency planning. Additionally, DFM has oversight responsibilities

for a multi-billion facilities construction and management portfolio that calls for construction of numerous state-of-the-art laboratories, office buildings and other support facilities.

The *Division of Real Property Policy (DRPP)* establishes, maintains and promulgates HHS and OS policy for the occupational safety and health and environmental programs, as well as for the historic preservation program. Reviews physical security requirements for HHS leased real property. Interprets Department of Energy policy on energy management issues and oversees implementation of energy related legislation with HHS. Establishes information and reporting standards for all above listed programs. Collects, assembles, and analyzes required information for reports to Congress, OMB, GSA and other Federal agencies.

- OS Executive Office (OSEO) - Advises the senior executives in OS on management and administrative issues. Provides resource management in the areas of budget, financial services, human resources, administrative services, and information management. Advises HHS components on all Departmental management programs, such as travel and Continuity of Operations (COOP). Provides overall administrative management to the OS customers in the SW DC complex. Supports and advises all HHS organizational components in the SW Complex on issues of space design, construction, space utilization, handicapped accessibility and rent management. Additionally, serves as the HHS/OS liaison with the General Services Administration.

The FY 2004 budget request will allow ASAM to carry out the following major objectives:

Office of Grants and Acquisition Management (OGAM)

- Continue to provide innovative solutions, guidance, assistance, performance measurement, training and advocacy in the above areas in order to achieve the best business value and ensure the public trust for Departmental program and operating funds in FY 2003 and FY 2004.
- Continue to foster the growth of Small and Disadvantaged Business Streamlined vendor outreach by conducting monthly sessions on a Department-wide basis.
- Continue to manage the Department-wide Grants Information System to provide a single repository of HHS grant awards made under nearly 300 different grant programs.
- Continue to manage and implement upgrades to the Department-wide Contracts Information System (DCIS), which feeds data to the Federal Procurement Data System.
- Provide training in grants, acquisition and logistics management for staff Department-wide.

- Lead government-wide Grants Management Committee, and streamline grants procedures within HHS.
- Manage the Department's purchase and travel card programs.

OGAM achieves the best business value and ensures public trust for Departmental program and operating funds by managing a Department-wide policy system which will provide innovative solutions, guidance, assistance, performance measurement, training and support in:

- Aiding beneficiaries and business organizations. HHS grants program and policy information was made available via the internet on GrantsNet. Provided individual written responses to over 1,500 requests from the public for grant information.
- Acquiring goods and services to meet program needs. \$6 billion, plus another \$373 million for the purchase card, was awarded in FY 2002.
- Managing the Department's assets, while supporting the Administration.
- Congressional and professional policy initiatives.
- Using electronic commerce to conduct business more effectively and efficiently.
- Providing oversight of HHS grant programs, which spend over \$203 billion annually.

Office of Human Resources (OHR)

- Continue efforts to consolidate bargaining units in the Department to support the Secretary's "One HHS" initiative. Consolidation of ten National Treasury Employees Union (NTEU) bargaining units into a single unit with recognition at the Office of the Secretary is targeted for FY 2003. Efforts to consolidate bargaining units within OPDIVs having multiple recognitions with the same union(s) will begin during FY 2003.
- Continue the consolidation of human resources (HR) services within HHS. Multiple HR offices in NIH and FDA were consolidated to bring HHS from 40 organizationally dispersed offices to seven at the end of FY 2002. In FY 2003, this project will continue, consolidating to four Departmental offices which will provide the full range of HR services to all employees, and achieve economies of scale and higher servicing ratios by eliminating the overhead of multiple offices. OHR will continue to manage this consolidation to improve servicing ratios and increase savings in FY 2004.
- In FY 2002, OHR planned and carried out a study of employee retention, focusing on what factors influence employees to stay with the Department and, using conjoint analysis, developing information on the relative importance of different factors. This information will allow HHS to improve retention by focusing attention on the factors identified by employees as key to their staying with the Department. OHR will manage this effort in FY 2003 and 2004.
- Continue efforts to promote cooperative labor-management relations throughout the

Department, in order to enhance mission achievement. Support cooperative labor-management initiatives to implement the President's management agenda, especially focused on managing human capital.

- Continue to provide oversight and technical guidance to the EEO Alternative Dispute Resolution (ADR) Workgroup in implementing the Departmental ADR Work Plan, to ensure continued monitoring, technical assistance and information sharing regarding Department-wide ADR activities and training efforts.
- Continue to provide analyses and reports to HHS senior management officials regarding under-representation of minorities and women in HHS employment, recruitment, hiring, and retention strategies for increasing the representation of minorities and women in the HHS workforce, and the presentation of other EEO concerns.
- Provide technical guidance to the OPDIVs in the preparation of Affirmative Employment Program Plans, so that the methodologies used are consistent HHS-wide and conform to EEO Commission management directives. Continue leadership of HHS EEO Officers' meetings, coordination of OGC/EEO Roundtables and plans for restructuring HHS EEO Programs to improve efficiency through the elimination of duplicative efforts and achieving economies of scale.
- Continue implementation of the HHS Plan for Employment of Persons with Disabilities, which consists of an HHS strategy, framework, guidelines, required actions and timetables to recruit, hire, develop, retain persons with disabilities and to provide reasonable accommodation and accessibility. Provide oversight and technical guidance in the implementation of reasonable accommodation plans at the HHS and OPDIV levels. Continue oversight and technical guidance to the reconstituted HHS Committee for Employees with Disabilities, charged with providing advice and recommendations to the Secretary on the employment of individuals with disabilities, and serving as a focal point for the concerns of employees with disabilities on employment matters.
- Facilitate Departmental compliance in the implementation of new regulations under Section 508 of the Rehabilitation Act, which require electronic information technology accommodation and accessibility for person with disabilities.

Office of Facilities Management and Policy (OFMP)

- Consolidate within a single office all planning and directing of the total physical facilities program Department-wide, including leasing, for all OPDIVs.
- Implement a Capital Planning Process that will rank funding priorities for all facilities activities.

- Develop and implement a strategy to compete or directly out source facilities operations and maintenance activities.
- Continue to establish policy and provide oversight for occupational safety and health and environmental programs Department-wide.

OS Executive Office (OSEO)

- Continue to streamline administrative services and procedures within OS through further consolidations.
- Improve communications and service agreements to our customers through customer surveys, and enhanced reporting and tracking systems.
- Continue to develop and standardize operating procedures for budget, human resources, administrative, and operational/facilities services. This will continue to result in customer satisfaction through innovative solutions and a strong focus on outcome measurement.
- Develop further enhancements to assure timely and accurate budget submissions.
- Develop enhanced Financial Management and Tracking Systems (with each customer component providing input), to assure accurate and timely reporting of financial commitments and internal financial management.
- Continue to streamline management support processes to assure timely performance management that tie to Secretarial priorities, as well as placing a strong emphasis on developing timely assurances for meeting ethical reviews and training.
- Continue to develop customer outreach initiatives such as expanding the OSEO intranet site, developing enhanced information packages to include brochures and handouts, continuing quarterly customer advisory meetings and assuring one-on-one customers sessions provide on-going communications.
- Continue to build strong business coalitions with customers, vendors, and partners to assure enhanced customer service.
- Continue to monitor and advance the Continuity of Operations Plan (COOP) for the SW DC Complex.

Rationale for the Budget Request

The FY 2004 request for ASAM is \$17,100,000, a net increase of \$404,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

OFFICE OF INTERGOVERNMENTAL AFFAIRS

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$5,622,000	\$6,108,000	\$6,130,000	+\$22,000
FTE	40	47	45	-2

Purpose and Method of Operations

The Office of Intergovernmental Affairs (IGA) is composed of a headquarters office and the ten offices of the Secretary's Regional Representatives. IGA undertakes a variety of assignments for the White House, the Secretary, the Deputy Secretary, and the Director of Intergovernmental Affairs in the areas of administration, management, and intergovernmental affairs. IGA also works closely with national intergovernmental interest groups and with individual State, local and tribal officials, ensuring that important lines of communication are maintained between all levels of government.

IGA coordinates a range of outreach activities and facilitates cross-cutting initiatives in the field. IGA develops close relationships with, and is the Secretary's chief representative to, governors, State legislators, mayors, tribal leaders, other elected and appointed officials, and their constituencies. IGA also tracks HHS region-specific, Federal and State legislative actions, and serves as a surrogate for the Secretary and Deputy Secretary in the Federal regions, informing State, local and tribal officials, the media and public of program initiatives of the Administration and the Department.

IGA's major objectives in FY 2004 will be to:

- Provide advice to State and local entities about the potential impact of proposed Departmental legislative, regulatory, and administrative decisions. This includes working with both the HHS Operating Agencies and with State and local officials throughout the process for implementation of legislation and regulations associated with welfare reform reauthorization. It also includes working with HHS representatives and State and local officials during the review process for comprehensive health care reform demonstration waivers and State plans for implementation of the State Children's Health Insurance Program (SCHIP), and other important Departmental activities.
- Provide Departmental leadership in the field in several areas, including all top Secretarial priorities and initiatives. This includes coordinating all aspects relating to the public announcement of grants to States, tribal government, and non profit grantees.

General Departmental Management

- Represent the Secretary and the Deputy Secretary in contacts with officials from other Federal agencies, the White House, State, local, and tribal governments, their representative organizations, and other outside parties.
- Promote general public understanding of programs, policies, and objectives of the Department.
- Coordinate the Department's tribal consultation responsibilities, pursuant to the Indian Self-Determination and Education Assistance Act (PL 93-638) and presidential Executive Orders on tribal consultation; to provide a single point of contact for nearly 700 American Indian/Alaska Native (AI/AN) tribes to access HHS program information and assistance.
- At the regional level, solicit a full range of viewpoints and disseminate Departmental information, initiatives, press releases, and decisions to stakeholders, including State, local and tribal officials, district Congressional staffs, business coalitions, interest groups, advocacy groups, the media and other regional constituents.

Rationale for the Budget Request

The FY 2004 request for IGA is \$6,130,000, a net increase of \$22,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

OFFICE OF THE GENERAL COUNSEL

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$35,593,000	\$39,268,000	\$39,412,000	+\$144,000
FTE	313	310	308	-2
HCFAC account ¹	[\$4,180,000]	[\$4,896,000]	[\$4,896,000]	[-]
HCFAC FTE	34	34	34	-

Purpose and Method of Operations

The Office of the General Counsel (OGC) oversees the provision of legal advice and representation to all components of the Department (except the Office of Inspector General), on all aspects of agency operations. OGC is responsible for meeting all of the legal needs of Departmental components in carrying out their respective duties and responsibilities. OGC currently manages over 7,000 litigation matters in court and before administrative tribunals; by FY 2004, this number will reach 10,000. In addition, attorneys in the Office of the General Counsel play key roles in policy formulation by advising senior officials about the Department's more than 300 programs.

OGC provides advice to its clients daily, often in the form of reviewing and relaying its opinion on products written by the OPDIVs. As partners with the OPDIVs participating in "One HHS," OGC's legal services assist in the achievement of the Department's outcome goals and management objectives. OGC works in tandem with its clientele, not substituting its judgement for the client, but rather serving as advisors by providing input on the legal implications of programmatic and policy decisions. This role also includes outreach responsibility for training, brainstorming on potential policy or programmatic decisions and providing other assistance that the client may need in carrying out its mission.

OGC's administrative and court litigation work supports all the program areas within the Department's portfolio and all the Secretary's priorities for the Department, including: food safety protections, organ donation, patient safety, welfare and health care reform, reducing the cost of prescription drugs for seniors, disease prevention, privacy protection, regulatory reform, Departmental reorganization, enhancing rural care, reducing the number of uninsured, child

¹ Funding for the Health Care Fraud and Abuse Control (HCFAC) program is appropriated separately and is a non-add to GDM. The FY 2003 and 2004 HCFAC amounts are estimates; final amounts may differ, pending agreement between the Secretary of HHS and the Attorney General.

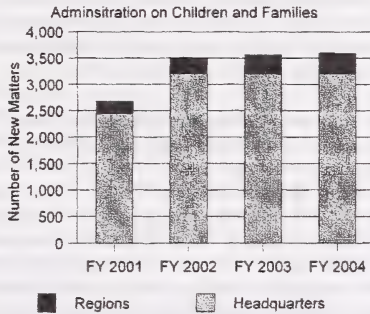
support enforcement, Native American tribal self-determination, Head Start, improving the Medicare+Choice program, and support for mental health initiatives. In addition, OGC works on both Departmental and Administration initiatives, such as the New Freedom Initiative, the Faith-Based Initiative, prevention of medical errors, improving health care quality (including Nursing Homes), malpractice reform, Temporary Assistance to Needy Families (TANF), Prescription Drug User Fee Act (PDUFA), Medicare reform/Centers for Medicare & Medicaid Services (CMS) management reform, Long-Term Care, Medicaid/State Children's Health Insurance Program (SCHIP) Reform, and support for Medical Records Privacy.

OGC accomplishes its mission through a structure of specialized headquarters divisions and ten regional offices. The headquarters divisions (e.g., General Law; Ethics)¹ are structured to have principal responsibility for providing policy guidance, direction and advice to the Department's major programs, while the regional offices are responsible for providing the full range of legal services to the Department's field operations.

Following are OGC's planned FY 2004 accomplishments, listed by major activity.

Administration for Children and Families (ACF)

Child Support (State and Tribal) The child support enforcement (CSE) program is a Federal/ State/tribal/local partnership to collect child support. The goal of the child support enforcement program is to increase parental involvement and financial support of non-custodial parents in the lives of their children and increase the economic independence of low income families by locating non-custodial parents; establishing paternity; establishing, modifying, and enforcing child support orders; and collecting and distributing child support payments. The Tribal child support program enhances Indian self-governance by enabling tribal governments to receive direct Federal funding for the operation of comprehensive child support enforcement programs. In FY 2004, OGC will provide legal advice and counsel to the program on issues related to promulgation of final Tribal CSE program regulations; review of an estimated 10-20 new applications for funding; legal review and evaluation of Tribal plan amendments; and oversight and monitoring of Tribal child



¹ OGC attorneys in the Civil Rights Division (CRD) and Food and Drug Division (FDD) report to the General Counsel for legal matters; however, their funding is provided by the Office for Civil Rights and the Food and Drug Administration, respectively. Accordingly, any increase in CRD or FDD legal work resulting from increases in OCR or FDA program activity shall be funded by OCR or FDA.

support programs. OGC expects new litigation involving defense of disapproval actions and disallowances.

In addition, OGC expects additional work because five States have not implemented certified automated data processing systems as required. OGC expects some to either seek hearings to contest the findings of certification reviews or the issuance of notices of intent to disapprove the State plan. It is also expected that they may seek judicial review in addition to or concurrent with any administrative review they may seek. States lose incentive funds if they fail to submit reliable data for each of five performance areas as determined by annual data reliability audits. OGC expects that some States will seek judicial review to contest the finding of unreliability. States are also subject to financial penalties against their TANF grants if their CSE programs are not in substantial compliance with program requirements; they fail to meet performance standards or they fail to submit complete and reliable data and the State does not correct the deficiency after an automatic one year corrective action period. OGC expects that States may appeal any penalty finding for FY 2002 both administratively and judicially.

Finally, the TANF Reauthorization proposals include a number of proposed child support changes covering distribution of support payments and other requirements with effective dates in FY 2004. New regulations and implementing guidance will be necessary. New regulations on safeguarding of information and confidentiality will also be in development. OGC also expects continuing litigation involving the denial of passports to persons with support arrearages if the threshold amount is lowered to \$2,500.

Head Start and Early Head Start Programs Head Start provides comprehensive child development services primarily to children of low-income families from birth through the age of mandatory school attendance through Head Start and Early Head Start programs operated by a network of approximately 1,500 local public and private agencies. In FY 2004, OGC will provide assistance to the program by advising on development of regulations and legal issues raised by applications for funding to purchase, construct and make major renovation to Head Start facilities; as well as, representing the program in litigation related to termination of poorly performing grantees and appeals of disallowances. OGC also anticipates that it will provide advice on issues related to the requirements for the Early Literacy initiative, particularly on the development and implementation of regulations relating to required grantee activities, and implementation through the Head Start program of other broad program themes being promoted by ACF, such as the Marriage initiative. These efforts will enhance the agency's efforts to ensure that children are ready to learn and will facilitate its efforts to enhance the quality of life for persons with disabilities, since up to ten percent of Head Start slots are available for eligible children with disabilities.

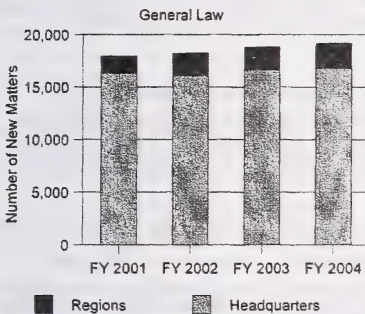
Temporary Assistance For Needy Families (State and Tribal) The TANF program provides benefits, limited to a maximum of five years, to needy families in exchange for participation in work-related activities. The program, which expired at the end of FY 2002, has been continued through a series of temporary legislative extensions and is expected to be reauthorized. The

program strengthens American families and promotes individual self-sufficiency by assisting needy families with children to prepare for, obtain, and retain employment; providing supportive services to prevent out-of-wedlock pregnancies; providing assistance in keeping families together; and decreasing the poverty rate of elderly caretakers of needy children. The TANF program enhances Indian self-governance by authorizing Tribes to determine which services/benefits to provide and whom to serve. In FY 2004, OGC will provide legal advice and counsel to the program on issues related to legal review and evaluation of TANF plans, review of TANF penalty decisions for misuse of funds, defense of penalty appeals, defense of TANF plan disapprovals, and integration of TANF program funds into consolidated Indian Employment, Training and Related Services Demonstration projects as well as with other programs intended to promote individual self-sufficiency.

General Law

E-Grants Project HHS, the major grant-making agency in the Federal Government, is the managing partner and, along with 10 other Federal agency partners, has become involved

recently in a Government-wide E-Grants Project, intended to improve and expand the use of electronic grants system for Federal agencies. Because of OGC's role as legal advisor to the Department on grants administration issues, the Office of the Assistant Secretary for Administration and Management (ASAM) asked OGC to assign dedicated legal resources to work closely with ASAM on this project.



Acquisition of the National Institutes of Health (NIH) Clinical Research Information System NIH has very recently begun conducting a series of acquisitions for a new Clinical Research Information System (CRIS), which is intended to modernize the systems support for

clinical care and collection of research data for intramural research programs to be used in the new Mark O. Hatfield Clinical Research Center (Clinical Center), still under construction and anticipated to be completed sometime in 2004. Given the critical importance of this new system to NIH's intramural research and the anticipated significant investment in it of both money and human resources, the final amounts of which are presently unknown, the NIH procurement and program staffs involved in this project recently asked OGC to provide legal advice to them on every step of the several procurements which will be involved in CRIS.

Health Centers (HC) OGC projects continued significant growth in the administrative tort and tort litigation areas for HCs. The President's Budget for FY 2003 builds on his initiative to create 1,200 new and expanded HC sites by 2006, to serve an additional 6.1 million patients; he

proposed to add 170 new and expanded sites in FY 2003, and 230 additional new and expanded sites in FY 2004. This increase in the number of sites may result in an increase in the administrative claims and litigation handled by the General Law Division.

Strategic Human Capital Management To improve EEO Compliance, OGC represents Regional Office agencies and the Centers for Disease Control and Prevention (CDC) in a large number of EEO cases before the Equal Employment Opportunity Commission (EEOC) and Federal Courts. CDC and various of its components have been increasing their requests for legal services in the labor relations and collective bargaining areas. The number of requests for representation in arbitrations arising from collective bargaining requests though small when compared to other personnel litigation at CDC nevertheless continues to grow. Personnel and Equal Employment Opportunity (EEO) cases for the FDA in the Department's regions also have been increasing because of referrals from their Regional and District Offices. Both FDA cases and the EEO cases that OGC handles for the Indian Health Service (IHS) often require travel outside the regional area, which adds substantially to the time required in defending the case. Handling these cases effectively and expeditiously is critical to these mission-driven health agencies because unresolved disputes in these areas adversely impact morale and demand the time and attention of management and the involved employees that are more productively devoted to the mission of the agency.

Indian Health Service A growing area of law is in IHS, not just health-related law. For instance, OGC provided legal advice and assistance to the Contracting Office of the IHS Area Office in Nashville on various issues related to the Federal Acquisition Regulations. This has included big and small issues, from advising on problems with copier contracts to multi-million dollar construction litigation.

Employee Relations Cases Virtually every HHS component with a Regional presence (e.g., FDA, CMS, OCR, ACF, IHS, OPHS) increasingly seeks OGC's assistance with employee relations matters. These clients seek either informal assistance (through legal advice, counseling and mediation services) and/or legal representation in administrative and judicial litigation. More and more regional managers are turning to OGC to provide needed hands-on advice and counsel regarding personnel problems. Since labor relations matters are among the most sensitive, time-consuming and mentally-taxing of all matters for most managers, OGC's assistance not only helps ensure compliance with employment laws and applicable collective bargaining agreements but also helps managers to better deal with employee issues; to resolve these issues promptly and effectively for the efficiency of the Federal service; and to get back more quickly to their substantive missions, thus ultimately supporting "One HHS" Management Goal 1 (Results-Oriented Management).

Ethics

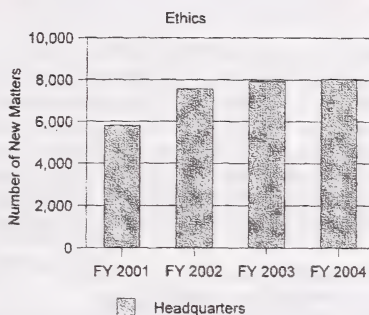
Consolidating Administrative Functions In order to establish "One HHS" and attain the management objective of consolidating administrative functions – as well as to exert more

control over policy development and ensure consistent Departmental positions on a number of controversial issues – the Secretary has created or reconstituted several advisory committees and located them administratively within the Office of the Secretary. This has resulted in an additional level of activity for OGC's Ethics Division. Because of the high profile nature of the issues presented to these committees, and the potential that ethics conflicts may be used to derail committee deliberations, the Ethics Division recently has had to assume primary, if not sole, responsibility for providing ethics support to the Executive Directors, Designated Federal Officials, and individual members of ten advisory bodies.

Ethics Program The Departmental Ethics Program resides within OGC which is tasked with developing training materials, publishing brochures, or traveling to do training sessions.

OGC has undertaken efforts to further the "Electronic Government" objectives outlined in the President's Management Agenda, by pursuing the development of an HHS ethics website and automated tracking systems. OGC plans to incorporate these two systems in its Law Department Enterprise Management System.

Regional Ethics Support OGC also provides ethics advice for the Secretary's Regional Director and other Regional Office managers and employees and coordinate and participate in all Regional Office ethics training activities.



Centers for Medicare and Medicaid Services (CMS)

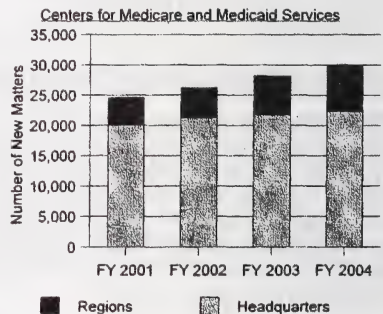
OGC expects to aid in achieving the Secretary's goals of increasing access to health care, enhancing health care quality and treatment, enhancing the quality of life for elder Americans, and enhancing the quality of life for persons with disabilities. In his February 28, 2002 statement before the House Budget Committee, the Secretary also stated his desire to strengthen the Medicare program by, for example, increasing access to prescription drugs, protecting against fraud and abuse, stabilizing the Medicare+Choice program and updating regulations and administrative procedures. OGC expects to be significantly involved in providing legal counsel and advice on all of these activities.

In addition to its workload connected with Secretarial initiatives, OGC expects to see the workload grow from annual major amendments to Medicare, Medicaid and SCHIP. In every year but one since 1999, Congress has passed and the President has signed legislation making substantial changes to CMS's programs. Much of that legislation has resulted in significant new work. OGC has written innumerable legal opinions, assisted in the promulgation of scores of regulations and defended against challenges to a number of the policy choices made.

Improving Access to Prescription Drugs The Secretary and the President have made improving access to prescription drugs one of their primary goals. OGC will be called upon to provide substantial assistance in reaching this goal. For example, as the Department continues to search for original ways to provide access to prescription drugs to Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries, OGC will provide substantial legal advice and litigation support for such initiatives.

Other ways in which OGC will aid in improving access to prescription drugs include continuing to defend litigation challenging State demonstration projects designed to extend prescription drug benefits to elderly and low-income residents, often by extending pharmaceutical manufacturers' obligations to pay drug rebates under the Medicaid Act to drugs purchased by expansion populations in the demonstrations. OGC is currently defending litigation associated with a Maine demonstration in the DC Circuit. A number of other States have pending demonstration project proposals that CMS anticipates may ultimately be approved, and litigation regarding such approvals is expected to extend into FY 2004.

Improve Health Outcomes OGC quality of care cases involving nursing homes enhance the lives and health of the residents in such facilities. These cases enforce provider compliance with Medicare and Medicaid conditions of participation geared towards assuring basic standards of quality in the care and treatment of nursing home residents. "Immediate jeopardy" cases in particular involve prompt intervention to prevent further serious harm, injury or even death to nursing home patients. Through OGC's continued support of CMS efforts to ensure quality nursing home care, OGC helps protect residents in those facilities and improve their lives. Consistent with its current work load, OGC anticipates that a substantial portion of its work in FY 2004 will focus on the quality of care in nursing homes. Through successful defense of penalties imposed on these facilities, OGC reinforces the requirement that the elderly be provided safe, appropriate care in nursing homes. Workload data shows that CMS will continue to use the additional resources dedicated



to its program to improve the quality of care provided in the nation's nursing homes more often and more vigorously, and that its need for OGC's legal support will increase accordingly.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)

OGC will assist CMS in applying PRWORA, which enacted restrictions on providing Federal public benefits to non-qualified aliens. PRWORA also contained a 5-year ban on providing certain Federal public benefits to "qualified aliens" and mandated deeming of income and resources of an alien's sponsor and the sponsor's spouse to the alien in determining the alien's eligibility for benefits. With the expiration of the 5-year period, deeming issues have now become more important. The application of the deeming requirements to the SCHIP program (which was enacted after PRWORA), has also raised issues which this office will need to address. OGC anticipates more work for its offices (not only CMS Division, but also, the regional offices and Children Family and Aging Division) on these issues as States begin to implement the deeming rules. Should Congress make changes in the restrictions on benefits for aliens, as some members have proposed, OGC will need to advise CMS and ACF on how to handle these changes.

Legislative Services

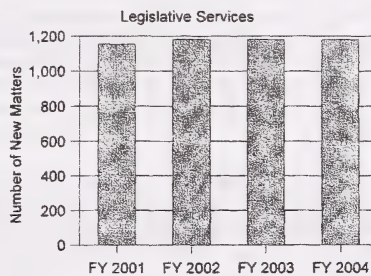
Government-wide Initiative - Faith-based and Community Initiative From the beginning of this Administration, matters related to the faith-based and community initiative (FBCI) have accounted for a substantial share of OGC's Legislation (GCL) Division's workload. OGC expects to continue to be involved in FBCI-related matters.

Strengthen American Families and Promote Individual Self-sufficiency - Welfare Reform

GCL remains a key player in the ongoing work to reauthorize and amend the Temporary Assistance for Needy Families (TANF) program, together with child support enforcement (CSE), child care, and other "welfare reform" programs. GCL continues to be heavily engaged in assisting HHS policy and program offices in negotiations with the concerned Committees. TANF and the "mandatory" funding for child care expired at the end of FY 2002 and is expected to be reauthorized. GCL assistance has been needed to attain a series of temporary legislative extensions.

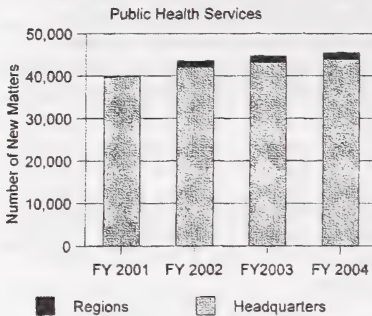
Medicare prescription (RX) Drug Benefits

GCL has drafted two bills to implement Presidential proposals to enhance prescription drug coverage for Medicare beneficiaries: the "Immediate Helping Hand" interim coverage proposal, and a bill to clarify authority for the RX drug discount card program. OGC will provide further legislative drafting assistance as needed.



National Health Service Corps (NHSC) and Health Centers (HC) GCL draft bills were incorporated into various bills pending in Congress to improve and ensure access to health care, including bills to reauthorize and improve the NHSC and HC programs. GCL continues to assist the Assistant Secretary for Legislation and other HHS staff in negotiations with the Congress on these bills. OGC will provide assistance (including drafting of authorizing or appropriations legislation) to advance the President's initiative to expand the HC network, as well as to resolve the ongoing problems with the HC tort claims judgment fund.

Preparedness GCL will continue to play a key role in drafting bioterrorism-related legislation, and in assuring the accuracy of HHS and other Executive Branch oversight testimony/ other public statements on chemical, biological, nuclear, and other terrorist threats.



Public Health Services

Health Resources and Services

Administration OGC will assist HRSA as it increases the number of Health Center sites to strengthen the health care safety net for those most in need, including programs to promote comprehensive care through integrated State health care delivery systems for women and children; and assist HRSA in expanding the Nurse Education Loan Repayment program to help address the national shortage of nurses.

Funding for this program has increased substantially since FY 2000.

Substance Abuse and Mental Health Services Administration OGC will assist SAMHSA in implementing its two new charitable choice laws which provide, among other things, that religious organizations, on the same basis as any other organization, may receive financial assistance under substance abuse programs administered by SAMHSA.

OGC will also assist SAMHSA in amending the Mandatory Guidelines for Federal Workplace Drug Testing Programs so as to establish standards for determining the validity of urine specimens collected from Federal employees; and assist SAMHSA in implementing a new emergency response grant program authorized by section 501(m) of the PHS Act and its new implementing regulations to fund activities relating to mental health and/or substance abuse emergencies.

Indian Health Service OGC will assist IHS in implementing the Indian Health Care Improvement Act that is due for re-authorization, and it is anticipated that this will result in additional legal work. Based on the proposed bills, the anticipated re-authorization is expected to include major changes and the addition of several new programs and authorities each of which

are expected to generate additional requests for legal advice and other legal support services.

Current IHS goals and initiatives call for an increase in the number of interagency agreements and cooperative agreements. This is expected to generate additional legal work regarding the negotiation, drafting, and review of such agreements as well as additional requests for legal advice regarding the administration of such agreements.

Centers for Disease Control and Prevention (CDC) OGC will provide advice to CDC on bioterrorism-related legal matters, including: evaluation of smallpox and anthrax State planning documents; negotiation of agreements with other Departments and private pharmaceutical companies for the provision and storage of vaccines and vaccine components.

National Institutes of Health (NIH) OGC will assist NIH in its efforts to reduce deaths, incidence and impact of chronic and infectious diseases; expand the health research base; improve detection and treatment practices for diseases and disabilities; and rapidly respond to public health emergencies. Further, OGC will assist NIH's Office of Technology Transfer in more aggressively protecting its intellectual property licenses against infringement.

Office of Research Integrity (ORI) OGC will assist ORI in developing procedures for addressing institutional whistle blower retaliation claims and in developing protocols to assist institutions in conducting scientific misconduct investigations.

Other Activities OGC will work with the Department of Justice (DOJ) on United States v. Philip Morris, Inc., et al., a case filed by the government in the District Court for the District of Columbia, in which the Federal Government is suing several tobacco manufacturers to recover Federal expenditures associated with the treatment of smoking-related diseases. Discovery is underway, and the PHS agencies involved (including CDC, FDA, NIH, SAMHSA, IHS and AHRQ) have performed extensive review of current and old files to identify, categorize, and produce relevant documents. In addition, OGC has assisted DOJ with preparing Federal government witnesses for depositions and at trial.

OGC will assist the National Institute for Occupational Safety and Health (NIOSH), the Department of Labor, and the Department of Energy in implementing the compensation system for workers who were exposed to hazardous materials while working in the Nation's nuclear facilities, including nuclear testing and weapons manufacturing.

OGC's Cross-Cutting Program Initiatives

Nursing Home Oversight Improvement (NHOI) Program

Since its introduction as part of the FY 1999 budget, the NHOI program has provided funding to States, through the Medicare and Medicaid programs, to conduct on-site inspections of nursing homes which participate in Medicare and Medicaid. As part of this nationwide effort, OGC –

working with both CMS and the Departmental Appeals Board (DAB) – has been diligent in increasing the number of sanctions against those nursing homes that are found to be in violation of health and safety rules.

NHOI litigation is expected to continue to increase. NHOI case receipts for new matters increased 24 percent from FY 1999 to FY 2000, exactly in line with forecasts. Similarly, though not at the rate expected, there was an increase in new matters in FY 2001 of 14 percent over FY 2000. In FY 2002, OGC did not experience as large an increase in matters received as in FY 2001. Within OGC's FY 2002 receipts was a larger-than-expected increase in NHOI hearing requests before the DAB (from 12 in 2001 to 30 in 2002), contributing to the overall increase in FY 2002 litigation work.

While it may appear that OGC is experiencing a decline in the receipt of new matters, in reality many of the new matters coming before OGC are more complex in nature than previously. Part of this phenomenon, as well as the continued upward trend in litigation, can be attributed to three recent policy changes by CMS:

- Allowing "Double G" appeals, when an enforcement remedy has been imposed immediately after two consecutive findings of actual harm;
- Allowing nurse aide training appeals, even when withdrawal of a facility's right to conduct nurse aide training is the only remedy imposed (previously, such appeals were allowed only when another sanction, such as a CMP, was also imposed); and
- Allowing "per-instance" CMP penalty appeals.

In FY 2003 and FY 2004, OGC will continue to devote extensive resources to defending the Secretary's authority to terminate noncompliant nursing home providers, absent immediate jeopardy. The Secretary's enforcement of the requirements of participation for long-term care providers, using the current survey and certification protocols, will also be defended as Constitutional and properly promulgated under the Administrative Procedures Act (APA).

Throughout FY 2004, OGC will also continue to work with CMS, OIG and DoJ to find the most productive means of sharing information on noncompliant nursing homes, so that the enforcement prerogatives of both agencies are preserved, and settlements initiated by DoJ with individual facilities are done in a manner consistent with CMS's legal requirements and policies.

The following tables illustrate OGC's NHOI workload history and projections, showing an upward trend:

General Departmental Management

Annual NHOI Litigation Work by Fiscal Year ¹						
	1999	2000	2001	2002	2003	2004
Court Litigation	87	104	109	126	146	168
Administrative Litigation	1,431	1,761	2,123	2,261	2,408	2,564
– Subtotal Litigation	1,518	1,865	2,232	2,387	2,553	2,732
Legal Advice	47	107	72	86	102	118
Total	1,565	1,972	2,304	2,473	2,655	2,850

New Matters Received by Fiscal Year ²							
	1998	1999	2000	2001	2002	2003	2004
Court Litigation	7	28	15	30	32	35	39
Administrative Litigation	428	588	708	807	707	778	855
Subtotal Litigation	435	616	723	837	739	813	894
Legal Advice	364	430	586	758	691	760	836
Total New Matters	799	1,046	1,309	1,595	1,430	1,573	1,730

Medical Records Privacy Regulation

The Medical Records Privacy Regulation provides uniform protection for all Americans of personal health information created by health care providers, health plans, and health care clearinghouses. The new standards include: limiting the non-consensual use and release of private health information; giving patients new rights to access their medical records and to know who else has accessed them; restricting most disclosure of health information to the minimum needed for the intended purpose; and establishing new requirements for access to records by researchers and others. Most covered entities must comply with the regulation by April 14, 2003; small health plans have one extra year to comply.

¹ Using legacy data OGC has been able to determine matters worked by regional staff. OGC revised this chart using existing data. OGC hopes to provide like information for its headquarters operations by calendar year 2004. FYs 2002-2004 are estimates, based upon year-to-date actuals through July 2002.

² FYs 2002-2004 are estimates, based upon year-to-date actuals through August 2002.

OGC will continue to assist CMS and the HHS Office for Civil Rights (OCR) in the promulgation of the Privacy Regulation, as well as eight other regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Based on the provisions of HIPAA, OGC will provide legal interpretations of the privacy provisions of HIPAA and implement regulations that can be used, in coordination with OCR, in the development of internal legal opinions, exception determinations, compliance guidelines, technical assistance resources, and consumer education tools.—In addition, OGC will also perform the following duties:

- Assist DoJ in defending the Privacy Regulation;
- Provide technical assistance to ensure compliance with the regulations;
- Train staff regarding the enforcement requirements of the regulations;
- Provide assistance in the development and review of confirming regulations and guidance documents. There are currently eight related regulations that are in various stages of developments; and,
- Provide client support for outreach and education functions with the public and special interest groups.

OGC's Legal Services Management Priorities

Legal Department Enterprise Management System (EMS). OGC's ability to track little more than half its workload (regional chief counsel and limited division information) requires OGC to use emerging technologies to implement decision management tools to more effectively track workload, time, and the general distribution of resources across OGC. OGC proposes to develop a Legal Resource Management Unit within existing staffing levels which will work with managers and practice group leaders to review existing and emerging workloads; prepare the OGC strategic plan establishing goals and objectives to support the legal needs of the Department, as well as the Secretary's management priorities and the President's Management Initiatives; provide managers and practice group leaders with data to determine the volume, timeliness, and quality of legal advice being provided to OGC clients; and recommend the deployment of work and resources across OGC which will allow OGC the flexibility of adjusting to changing workload demands.

In developing an EMS, OGC devised a strategic plan and followed the enterprise infrastructure management guidance developed for the Department. In Phase I, an OGC Technology Study committee, assisted by a contractor, reviewed the IT needs of the office. OGC continued with Phase II in FY 2002 by identifying three vendors whose off the shelf systems would provide OGC a system requiring little modification, and developed a statement of work. OGC plans to implement an office-wide deployment of the time and matter tracking system during Phase III in

FY 2003 with full implementation by January 2004.

Workforce and Succession Planning, and Staff Recruitment and Development. OGC experienced a substantial number of retirements when early outs and buyouts were offered to OGC employees in the mid-1990s. OGC's next retirement bulge is approximately four years away. Formal workforce and succession planning exercises will provide needed information regarding the skills that OGC should develop within its workforce, such as counselors, litigators, regulation writers and managers. OGC will work with its clients to better understand the skill sets that the new, emerging workforce requires. OGC will establish staff development (e.g., core competencies) requirements to support the changing legal needs of the Department. Staff development includes formal and informal training, annual management/leadership meetings (spring and fall), new attorney orientation training, conferences to better understand the demands of emerging administration initiatives, and trial advocacy training sessions.

Due to a government-wide problem in recruiting and retaining legal staff in a highly competitive legal market, OGC developed a strategic recruitment plan in FY 2001 that entails attending public service forums early and on a regular basis; visiting law schools nationwide; maintaining current resumes on file of potential candidates; keeping in contact with prospective candidates; sending out Vacancy Announcements to law schools, bar associations (including minority bar associations) and relevant not-for-profit organizations; developing a Law School Intern Program; considering financial incentive and retention awards; and using term attorneys for certain aspects of legal work.

Contract Paralegal Pilot Project. OGC was one of the first Federal agencies to hire paralegals (GS-950 job series) after that job series was created. OGC intends to increase its use of paralegals, which will increase attorney productivity at lower salaries, and proposes to explore the usefulness of paralegals in other areas of its operations. To this end, OGC developed a small test pilot in FY 2001 to use five contract paralegals in three headquarter divisions and to monitor their performance and the performance of career paralegals in other offices. The offices are reporting considerable success and efficiency in utilizing paralegals for legal research, review, and litigation support activities. This cost effective way of increasing OGC attorneys' ability to professionally handle the increasing litigation workloads and more complex legal matters could be expanded by increasing the number of paralegals.

Expand Practice Area Workgroups. In order to help the client agencies improve and strengthen program guidance, these groups will develop recommendations for policy and regulatory amendments. OGC completed major national training conferences for the existing practice area groups: Bankruptcy, Nursing Home Oversight Improvement Program, Medicare Secondary Payer (MSP) litigation, HIPAA Administrative Simplification, and the Faith Based Initiative.

Rationale for the Budget Request

The FY 2004 request for OGC is \$39,412,000, a net increase of \$144,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

OFFICE OF THE GENERAL COUNSEL

Program Impact Data¹

OGC Office/Client	FY 2002		FY 2003		FY 2004	
	Matters	FTE	Matters	FTE	Matters	FTE
Administration for Children and Families/ Administration on Aging	3,584	25	3,646	25	3,678	24
General Law	18,251	81	18,822	81	19,153	81
Ethics	7,572	8	7,942	8	8,042	8
Centers for Medicare & Medicaid Services	16,956	69	17,316	66	17,697	66
NHOI Program	2,332	57	3,655	57	4,836	57
HCFAC	6,949	34	7,244	34	7,519	34
– Subtotal CMS	26,237	160	28,215	157	30,052	157
Legislative Services	1,180	8	1,180	8	1,180	8
Public Health Service	43,534	48	44,693	48	45,501	47
Immediate Office	–	17	–	17	–	17
– Total	100,358	347	104,498	344	107,606	342

The numbers above include both cases and items. A case is one which has actually been filed, or which either HHS or the Department of Justice is preparing to file. An item is each discrete request for legal services, including formal legal opinions as well as internally generated items of work, conferences, meetings, and informal advice.

¹FY 2002 FTE are actual usage; other FTE are projected.

DEPARTMENTAL APPEALS BOARD

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$8,079,000	\$8,902,000	\$8,935,000	+\$33,000
FTE	71	75	72	-3

Purpose and Method of Operations

The Departmental Appeals Board (DAB) provides impartial, independent hearings and appellate review, issuing final decisions under more than 60 statutory provisions governing HHS programs. The DAB is a STAFFDIV in the Office of the Secretary, but most of its functions are mandated by statute. Cases are initiated by outside parties who disagree with a determination made by an HHS agency or its contractor; outside parties include States, universities, Head Start grantees, nursing homes, clinical laboratories, doctors, and Medicare beneficiaries.

Disputes heard by the DAB may involve over \$1 billion in Federal funds in a single year. DAB decisions have national impact, ensuring consistency on issues affecting States, universities, and non-profit organizations receiving grants, as well as Medicare providers and beneficiaries. In addition, DAB decisions about certain cost allocation issues in grant programs have government-wide impact since HHS is the "cognizant agency" whose decisions bind other Federal agencies.

The DAB is organized into three Divisions which support DAB judges:

- the Appellate Division supports the Board Members who preside in various types of cases;
- the Civil Remedies Division supports Administrative Law Judges (ALJs) who conduct evidentiary hearings; and
- the Medicare Operations Division supports Administrative Appeals Judges (AAJs) who review decisions by Social Security Administration (SSA) ALJs.

In addition, the Alternative Dispute Resolution Division provides mediation services in DAB cases and promotes use of dispute resolution methods that reduce administrative costs. The functions of all four Divisions are described in more detail below.

Appellate Division (Board Members) – DAB Board Members are judges with extensive adjudication experience who, acting in panels of three, issue decisions with the support of the staff attorneys and a paralegal in the Appellate Division. In some cases, Board Members conduct de novo review, including holding an evidentiary hearing if one is needed. In other cases, Board Members provide appellate-type review of decisions by DAB ALJs or other ALJs.

Board review ensures consistency of administrative decisions, as well as adequacy of the record and legal analysis before court review. For example, Board decisions in grant cases promote uniform application of OMB cost principles. Board decisions also provide precedential guidance to DAB ALJs applying ambiguous or complex requirements related to healthcare quality or fraud and abuse. In cases involving allegations of research misconduct, scientists may serve on a panel with Board Members to assist in resolving scientific issues. Although these cases are not numerous, they are resource-intensive.

In addition, Section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) mandates that the DAB:

- Review Medicare National Coverage Determinations (NCDs) upon the filing of a complaint by an aggrieved party; and
- Review SSA ALJ decisions regarding Medicare Local Coverage Determinations (LCDs).

Board Members will preside in these cases. Section 522 went into effect on October 1, 2001, but HHS delayed full implementation pending final procedural regulations. (HHS has said in court and to Congress that the publication date will be no later than October 1, 2003.)

Civil Remedies Division (ALJs) – DAB ALJs are supported by attorneys and paralegals in the Civil Remedies Division. These ALJs conduct adversarial hearings in proceedings that are critical to HHS healthcare program integrity efforts, as well as quality-of-care concerns. Hearings in these cases may last up to a week and involve complex clinical issues (e.g., license revocations under the Clinical Laboratory Improvement Amendments; patient dumping cases under the Emergency Medical Treatment and Labor Act). The Medicare statute requires an ALJ hearing in these cases. They may also raise legal issues of first impression.

This caseload has increased dramatically in the last six years, primarily due to hearing requests by nursing homes. An estimated 1.6 million elderly and disabled people receive care in approximately 17,000 nursing homes across the country. States receive Federal funding to conduct surveys of nursing homes participating in Medicare and Medicaid. CMS has been working with States to improve surveys and to crack down on poor performing facilities. CMS also expanded appeal rights. As a result of these changes, hearing requests per year from nursing homes rose from 30 in FY 1995 to over 800 in FY 2002. Enforcement efforts for other types of providers, such as clinical laboratories, are also generating more cases.

Beginning in FY 2003, DAB ALJs will also receive civil money penalty cases for failure to comply with the medical records privacy requirements recently issued under the Health Insurance Portability and Accountability Act (HIPAA).

Medicare Operations Division (AAJs) – With support from Medicare Operations Division (MOD) attorneys and analysts, these Judges comprise the Medicare Appeals Council, which

reviews decisions by SSA ALJs in cases involving Medicare entitlement, coverage, and payment issues.

MOD has increased both the quality and rate of case dispositions (from 1,000 up to 9,000 per year), with no increase in permanent staff until a few positions were added in FY 2002, including two additional AAJs. Productivity gains have not all translated into reduction of backlog, however, since the caseload has increased from roughly 1,000 cases received in FY 1995 to 9,129 cases received in FY 2002 (a rate of roughly 20 percent per year). There are more aged and disabled Medicare beneficiaries overall, as well as more claims per individual. Providers and suppliers more frequently contest results of pre- and post-payment audits, as well as routine claims denials.

The provisions of BIPA are likely to substantially increase both the numbers of cases and the work required on each case. However, the President's Budget includes some legislative proposals to mitigate the burden on DAB, including a proposal to amend BIPA by increasing the decision-making timeframe for DAB Medicare appeals.

Medicare Appeals Council review is important to:

- Ensure that the interpretations applied to individual claims are consistent with the statute and regulations;
- Protect beneficiary rights often overlooked by contractors and SSA ALJs focusing on clinical issues, rather than due process;
- Ensure that Medicare requirements (such as statutory limits on scope of Medicare benefits) are applied uniformly nationwide;
- Ensure that the administrative record is complete and the administrative decision is clearly articulated, before court review; and
- Ensure that providers are held to standards only if they had timely, adequate notice.

Alternative Dispute Resolution (ADR) Division – Under the Administrative Dispute Resolution Act, each Federal agency must appoint a dispute resolution specialist and must engage in certain activities to resolve disputes by informal methods, such as mediation, that are alternatives to adjudication or litigation. The DAB Chair is the Dispute Resolution Specialist for HHS and oversees ADR activities under the HHS policy issued under the Act. Staff of the ADR Division provide mediation services in cases filed with DAB, and provide or arrange for mediation services in other HHS cases, provide training and information on ADR techniques (including negotiated rule-making), and assist HHS program agencies in establishing ADR systems.

This section sets out what each DAB Division will accomplish in FY 2003 and plans to accomplish in FY 2004. It also describes management accomplishments, including how the DAB will address the management priorities set by the Secretary and OMB.

Board Members – Appellate Division

In FY 203 and FY 2004, the Board Chair (the DAB head) and her Deputy will continue to work on management and administrative activities described below, as well as activities such as the following: providing training on management and other areas, responding to congressional requests for information, interacting with outside parties on process improvements, and coordinating with program agencies on regulation development and other activities affecting the DAB.

The Board Members (including the Chair and her Deputy), acting in panels of three with the support of the Appellate Division, will accomplish the following additional tasks in FY 2003:

- Receive 160 new cases, docketing and processing them by: setting procedures appropriate for the type of case and the issues raised, ruling on motions, reviewing and analyzing briefs and exhibits, researching legal issues, and holding evidentiary hearings or conferences for oral argument or otherwise taking steps to develop the record;
- Continue to process 106 cases open at the start of the year through similar actions;
- Develop, review, edit and issue plain English decisions in 59 cases, generally within 30 days of the closing of the record and then post them on the internet;
- Close 47 additional cases due to settlement, dismissal, or other means; and
- Maintain the quality of the decisions so that they will be infrequently appealed to court and rarely overturned.

In FY 2004, the Board and Appellate Division plan to:

- Receive 200 new cases, docketing and processing them as described above;
- Continue to process 160 cases open at the start of the year;
- Develop, review, edit and issue decisions in 57 cases, generally within 30 days of the closing of the record, and then post them on the internet;
- Close 40 additional cases due to settlement, dismissal, or other means; and
- Maintain the quality of the decisions so that they will be infrequently appealed to court and rarely overturned.

Case projections are based on a number of assumptions, including:

- Four Board Members available to decide cases;
- Receipt of 20 NCD cases per year in FY 2003 and FY 2004 and of 30 LCD cases in FY 2004;
- No appeals of ALJ decisions in HIPAA medical records privacy cases;
- Increased Medicaid appeals by FY 2004 due to more enforcement activity;
- Increased appeals in discretionary grant program and Child Welfare Services programs over FY 2002 levels, which were abnormally low; and
- Increases in decisions issued by DAB ALJs, as described below;

Cases closed without a decision may still have required considerable effort.—For example, one research misconduct case settled after the panel held 7 days of hearing and issued numerous rulings, consuming 608 hours of Board Member time, and 431 hours of staff attorney time.

DAB Administrative Law Judges – Civil Remedies Division

In FY 2003, DAB is expected to have 8 ALJs (including the Chief ALJ, who spends considerable time on management activities, such as those described below). These ALJs, with support from the Civil Remedies Division (CRD), will:

- Receive 1,005 new hearing requests, including 15 new privacy enforcement cases under HIPAA, docketing and processing them by: setting procedures, ruling on motions, reviewing and analyzing briefs and exhibits, researching legal issues, issuing subpoenas, and scheduling and holding pre-hearing conferences and evidentiary hearings meeting Administrative Procedure Act requirements;
- Continue to process 903 cases open at the start of the year through similar actions;
- Develop, edit, and issue decisions in 160 cases, and then post them on the internet;
- Close 810 additional cases due to settlement, withdrawal, or other means; and
- Begin to implement process changes to increase efficiencies.

In FY 2004, the ALJs and CRD plan to:

- Receive 1,149 new hearing requests, including 60 HIPAA medical records privacy cases, docketing and processing them as described above;
- Continue to process 938 cases open at the start of the year;
- Develop, edit, and issue decisions in 160 cases, and then post them on the internet;
- Close 815 additional cases due to settlement, withdrawal, or other means; and
- Evaluate and refine process changes to increase efficiencies.

Caseload projections are based on a number of assumptions, including:

- Cases under current jurisdiction will increase at a rate of 10% in FY 2003 and FY 2004;
- ALJs hired at the end of FY 2001 will be more productive in FY 2003 than in FY 2002; and
- Enforcement of nursing home requirements will remain relatively stable.

The projected receipts do not include potential new workloads that may be added to DAB jurisdiction. Although many of the provider enforcement cases settle, generally this is not until the DAB has expended considerable effort on case processing (e.g., scheduled a hearing) or has mediated the case.

Administrative Appeals Judges (Medicare Appeals Council) – Medicare Operations Division

In FY 2002, the DAB hired two Administrative Appeals Judges (increasing the total to four). The Administrative Appeals Judges will spend time in both FY 2003 and FY 2004 responding to requests for information from Congress, OIG, and GAO, providing training on Medicare Appeals, revising the procedural regulations for these cases, and taking other steps to reduce the flow of cases to the DAB.

In FY 2003, the Administrative Appeals Judges, and Medicare Operations Division (MOD) staff, will also:

- Receive 11,400 requests for review of SSA ALJ decisions in Medicare cases, docketing them, requesting and processing case files from Medicare contractors, analyzing briefs and record documents, and researching legal issues;
- Continue to process 13,930 cases open at the start of the year through similar actions;
- Dispose of 11,000 cases through decisions, dismissals, or other means; and
- Evaluate and refine management and efficiency initiatives, such as redesign of the MOD intake and processing procedures.

In FY 2004, the judges and staff plan to:

- Receive 15,448 requests for review of lower level decisions, docketing and processing them as described above;
- Continue to process 14,330 cases open at the start of the year; and
- Close 11,500 cases through decisions, denials of review, dismissals, or other means.

Case projections are based on a number of assumptions, including:

- Judges and other staff hired in FY 2002 will be more productive in FY 2004 than in FY 2003, as they gain more experience;
- Some factors that contributed to high case closings in FY 2002 (settlements, technical dispositions and use of temporary AAJs) will not be present in later years; and
- CMS and contractor program integrity efforts will remain relatively stable.

The projections do not include the potential workload effect from provisions of § 521 of BIPA.

Alternative Dispute Resolution Division

In FY 2003 and FY 2004, the ADR Division will provide mediation, facilitation, or ombudsman services in 77 cases (including 17 nursing home enforcement cases) and will conduct 12 ADR classes, training hundreds of employees in conflict resolution subjects such as basic mediation skills, mediation skills for lawyers, negotiated rulemaking procedures, and ADR overview.

The Division also plans to:

- Increase the use of mediation in DAB cases, particularly in nursing home cases;
- Continue its ADR leadership role in HHS; and
- Continue to work with staff in other HHS offices and the local Federal ADR community to advance joint ADR goals.

The DAB also continues to improve efficiencies in cases and in management overall. In FY 2003 and FY 2004, DAB will:

- Improve internet access to DAB decisions and to information on procedures and practice;
- Improve efficiencies in use of internet research tools available to staff;
- Improve availability and use of management information from case tracking databases;
- Improve database systems to provide better information;
- Begin to transition to electronic records capability;
- Continue interactions with representatives of providers, States, and others who appear before the DAB to receive input on how to improve services;
- Increase use of video conferencing for hearings, where appropriate;
- Evaluate and refine the redesign of the Medicare Operations Division; and
- Evaluate test system for faster case processing in the Civil Remedies Division.

Rationale for the Budget Request

The FY 2004 request for DAB is \$8,935,000, a net increase of \$33,000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

DAB must continue to process the increasing number of requests for hearings and appellate review (some under regulatory deadlines) currently within its jurisdiction, such as OIG fraud and abuse cases and CMS provider enforcement and claims cases. In addition, DAB must hear enforcement cases under the HIPAA privacy regulations, which go into effect in FY 2003. Despite some increase in staff, plus management and efficiency initiatives that have improved productivity, DAB's pending caseload continues to increase as case receipts increase. The caseload per judge continues to be high.

OFFICE ON DISABILITY

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	—	\$350,000	\$351,000	+\$1,000
FTE	—	3	3	—

Purpose and Method of Operations

The Office on Disability (OD), created in 2002, serves as the principal advisor to Congress on the Administration's disability-related health and human services initiatives, and the principal advisor to the Secretary and the Department on Congressional activities related to developmental disabilities. OD also maintains communications with executive officials of the White House, OMB, other Executive Branch agencies, members of Congress and their staffs, non-governmental organizations and associations, and selected disabilities programs.

OD responsibilities include: advising the Secretary on all policy matters relating to HHS legislation on disabilities; serving as an information resource for members of Congress and staff on HHS disabilities programs, State Developmental Disabilities Councils Program and the Protection and Advocacy Grants Program and initiatives; providing guidance on the development and analysis of Departmental legislation and policy, including formulation of the budget; directing and coordinating legislative initiatives to ensure consistent and strong advocacy before Congress; and securing Congressional enactment of program and policy reform proposals.

The major objectives of OD in FY 2004 will be to:

- Advance the Administration's health and human services legislative agenda before the Congress. This includes analysis and resolution of issues raised by Members of Congress and Congressional staff during consideration of HHS authorizing and appropriating legislation on disabilities issues.
- Provide quality service and information to Members of Congress and staff concerning HHS programs, grants, and initiatives. Evaluate the national impact of Federal programs on individuals with mental retardation and collaborate and partner with other Federal, State and local agencies and private sector organizations to promote and achieve Presidential goals for individuals with mental retardation and develop and disseminate information to increase public awareness of mental retardation.
- Coordinate Departmental participation in Congressional hearings, mark-ups and

conference committee meetings on disabilities programs. This includes arranging briefing sessions, identifying witnesses, supervising, drafting, and clearing testimony and position papers, communicating the Administration's positions to the Congress, and advising Department officials of the results of Congressional action.

- Standardize all operations of OD, so as to ensure timely, quality information is provided to the Secretary, other Executive Branch departments, and Capitol Hill for disabilities, protection and advocacy issues.
- Implement and fully utilize a new inter-departmental disabilities communications network with the four programs: the State Development Disabilities Councils, the State Protection and Advocacy Systems, the University Centers for Excellence Developmental Disabilities, and Project of National Significance.

Rational for the Budget Request

The FY 2004 request for OD is \$351000, a net increase of \$1000 above the FY 2003 President's Budget. This level includes a cost savings from the consolidation of administrative functions and the implementation of effective workforce planning and human capital management strategies.

OFFICE OF GLOBAL HEALTH AFFAIRS

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$4,293,000	\$4,310,000	\$9,326,000	+\$5,016,000
FTE	55	56	56	—

Purpose and Method of Operations

The Office of Global Health Affairs (OGHA) is a newly-created STAFFDIV, formed from the Office of International and Refugee Health and the Office of International Affairs. OGHA's mission is to promote the health of the world's population by advancing the Department's global strategies and partnerships, thus serving the health of Americans.

The increasing importance of global health issues – especially HIV/AIDS, tuberculosis, and malaria – has necessitated that the US government in general, and the Department of Health and Human Services in particular, take a more prominent position in the global health arena.

OGHA provides policy advice, leadership and coordination of international health matters across HHS, including leadership on major cross-cutting global health initiatives (e.g., HHS-USAID Afghanistan Health Working Group, US-Mexico Border Health Commission, US-Russia Health Committee, US-South Africa Cooperation Forum Health Committee) and maintaining the Department's relationships with regional and global organizations (e.g. World Health Organization, United Nations Children's Fund, Pan American Health Organization).

OGHA provides expert advice on international health policy on behalf of the Department as part of the US Government inter-agency process, e.g., related to the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Prevention of Mother to Child Transmission of HIV, negotiation of free trade agreements, health and sustainable development, climate change, environmental health, and others. OGHA participates in policy development and reform efforts, including priority-setting related to multilateral health organizations, notably the World Health Organization, Pan American Health Organization, and United Nations Children's Fund (UNICEF). Other multilateral fora to which OGHA provides expert advice through the inter-agency process include the Group of Eight (G8), the Organization of Economic Cooperation and Development OECD), UNESCO, the Asia Pacific Economic Cooperation (APEC) and others. OGHA also:

- Represents the US Government and HHS on international health issues to other governments, international organizations and US non-governmental constituencies.

- Provides effective policy guidance, coordination and advocacy related to refugee health particularly refugees in the United States, and to other humanitarian issues such as trafficking in persons.
- Promotes key bilateral (country-to-country) relationships in the health sector, particularly with but not limited necessarily to Canada, Egypt, India, Israel, Japan, Mexico, Russia and other Newly Independent States, South Africa, the United Kingdom, and Vietnam.
- Strengthens cooperation with Mexico through the Health Working Group of the US-Mexico Binational Commission. Priority areas and initial bilateral collaboration include: women's health, migrant health, immunizations, aging issues, substance abuse and tobacco prevention, and epidemiological surveillance.
- Provides support for the Secretary of HHS as US Commissioner for the United States section of the US-Mexico Border Health Commission, including logistical arrangements, meeting agendas, meeting minutes, and working with contractors.
- Manages the HHS Biotechnology Engagement Program (BTEP), including approval of more than 20 high-priority public health projects and engaging several hundred former Soviet scientists (including former bio-weapons scientists) in peaceful research activities. In addition, continues to sustain and strengthen cooperation with Russia through the US-Russia Health Committee.
- Promotes cooperation on emerging and re-emerging infectious diseases through appropriate international mechanisms and international relationships including the US-Japan common agenda, US-European Union (EU) Trans-Alliance, the Indo-US Vaccine Action Program, the Asia Pacific Economic Cooperation, and bilateral relationships with countries such as China, Egypt, Mexico, Russia, South Africa, and the EU.
- Partners on international health matters with other Federal agencies, including the Agency for International Development, the Environmental Protection Agency, and the Departments of State, Commerce, Defense, Education, and Energy.
- Supports International Health Attaché positions of HHS in four locations: US Mission in Geneva, Delhi (India), Hanoi (Vietnam), and Pretoria (South Africa). The attaché in Pretoria is southern Africa regional position for the Southern African Development Council (SADC), which includes 15 African countries.
- Leads the HHS effort to develop a program of cooperation with the Afghanistan Ministry of Public Health, for which a Memorandum of Understanding was recently completed. OGHA is working with its Afghan counterparts and has assisted various HHS agencies in determining how they can assist in the reconstruction of Afghanistan's health sector; OGHA also lead HHS's contribution to a HHS-USAID Afghanistan Health Work Group.

- Continues to be heavily involved in all aspects of the development of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Based in Geneva, the GFATM is a new organization being created to disburse approximately \$2 billion to developing countries to support prevention, treatment and care programs for these three major global diseases. HHS provides approximately half of the US contribution and the Secretary serves as the US representative to the Fund's Board. OGHA staff serve on various international working groups to provide input into the Operations of the fund, and support the Secretary in his role as US representative.

Rationale for the Budget Request

The FY 2004 request for OGHA is \$9,326,000, a net increase of \$5,016,000 above the FY 2003 President's Budget. This level provides \$5,000,000 for a new health initiative in Afghanistan, \$32,000 to allow OGHA to maintain essentially the same level of activity for other programs, and savings of \$16,000 from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies.

Included in the FY 2004 request is \$4,015,000 to continue efforts of the US-Mexico Border Health Commission. The goals of the Commission include: 1) institutionalize a domestic focus on border health, which can transcend political changes, and 2) create an effective venue for binational discussion to address public health issues and problems which affect the US/Mexico border populations.

OGHA will also continue efforts with the State Department to support the Biotechnology Engagement Program (BTEP). Funds are transferred from the State Department to OGHA to support the program. BTEP was created to reduce the risk of bioterrorism by engaging former soviet biological scientists in areas of research and development that address priority public health concerns in the former Soviet Union.

Reimbursable FTE and funds are central to the effective operation of OGHA. In FY 2004, an estimated \$50,000,000 in reimbursable funds will support OGHA functions. Reimbursable funds support the following: the entire core refugee health function in OGHA; the International Health Attaché positions at the US Missions in Geneva, New Delhi, Pretoria, and Hanoi; core bilateral program positions in OGHA including those associated with cooperation with China, Egypt, the European Union (EU), Israel, India, Japan, Mexico, Russia, South Africa; and Vietnam among others; core functions associated with HHS involvement in multilateral health organizations; policy and related program cooperation with the Agency for International Development (AID) and several of its missions, including but not necessarily limited to Africa, Egypt, India, and Russia; and key public health positions with AID's Office of Foreign Disaster Assistance.

Afghanistan Health Initiative

In recent months, through surveys and assessments carried out by HHS and staff at the Centers for Disease Control and Prevention, the international community has learned much about the dismal health situation in Afghanistan. Health care, particularly for mothers and children, is practically nonexistent for much of the population. HHS has begun to develop a program of cooperation in maternal and child health with the Afghan Ministry of Health (MOH) to achieve the following objectives:

- Demonstrate the ongoing commitment of the United States to Afghanistan's reconstruction and to the Karzai Government;
- Bolster the ability of the Karzai Government to fulfill its promise to provide essential services;
- Provide direct health care to the Afghan population through the creation of five maternal and child health teaching clinics throughout the country;
- Provide opportunities for the training of local Afghan health care workers in modern medicine; and
- Provide a vehicle for expatriate Afghan health workers to return to Afghanistan.

As a first step in accomplishing these goals, HHS has developed a partnership with the Department of Defense (DoD) and the US Agency for International Development (USAID). A team of HHS and DoD personnel recently traveled to Kabul to meet with the Afghan Minister of Health, USAID, and a variety of United Nations agencies and non-governmental organizations to discuss appropriate HHS involvement in a DoD-proposed project to rehabilitate Rabia Balkhi Women's Hospital in Kabul. The team assessed the hospital, determined its appropriateness as a teaching facility, and ensured that this is indeed a priority activity in which the Government of Afghanistan wishes HHS to be involved. The Afghan Minister of Health has given her full endorsement to this activity.

The HHS-DoD team also recommended the development of a satellite teaching facility ten kilometers outside of Kabul to focus on the special needs of the rural population. Beyond these initial two facilities, plans are underdevelopment for creating three additional teaching clinics throughout the country, for a total of five maternal and child health teaching clinics. Each facility would provide direct health care to patients and training to health care workers at all levels, including physicians, nurses, midwives, community health workers and others. Once trained, these health care workers could be dispatched throughout the rural areas of Afghanistan, the location of the country's overwhelming health care needs. Each clinic would also be an entry point for returning Afghan expatriates who wish to provide training and volunteer services to clinics and hospitals around the country.

To carry out this activity, OGHA is requesting \$5,000,000 to support health efforts in Afghanistan, including the establishment of a maternal and child health teaching clinic at Rabia Balkhi Hospital and four satellite clinics outside of Kabul.

OFFICE OF GLOBAL HEALTH AFFAIRS

Sources of Funding

ACTIVITY:	FY 2002 Enacted	FY 2003 Pres Budget	FY 2004 Estimate	Change
GDM appropriation (formerly in IOS)	\$300,000	\$310,000	\$311,000	+\$1,000
Afghanistan Health Initiative	—	—	5,000,000	+5,000,000
US-Mexico Border Health Commission (formerly in OPHS)	3,993,000	4,000,000	4,015,000	+15,000
Biotechnology Engagement Program (transfer from USAID)	9,000,000	not yet determined	not yet determined	
Subtotal, Appropriated resources	\$13,293,000	\$4,310,000	\$9,326,000	\$5,016,000
Reimbursables (estimated)	35,860,000	42,000,000	50,000,000	+8,000,000
TOTAL	\$49,153,000	\$46,310,000	\$59,326,000	+\$13,016,000

OFFICE OF PUBLIC HEALTH AND SCIENCE

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$131,188,000	\$134,174,000	\$139,184,000	+\$5,010,000
FTE	328	340	340	-

The Office of Public Health and Science (OPHS) provides leadership to the Nation on public health and science, and communicates on these subjects to the American people. OPHS is a unique Staff Division in the Department in that it performs both policy and program roles. OPHS is led by the Assistant Secretary for Health (ASH), whose chief interest is promoting, protecting, and improving the Nation's health. This role encompasses responsibilities as senior advisor for public health and science to the Secretary thereby providing senior professional leadership on population-based public health and clinical preventive services, directing a variety of program offices that house essential public health activities, providing senior professional leadership across HHS on White House and special Secretarial initiatives involving public health and science, and guiding and providing technical assistance to the ten Regional Health Administrators.

OPHS includes the ASH, the Office of the Surgeon General, the Office of HIV/AIDS Policy, the Office of Population Affairs, the Office of Disease Prevention and Health Promotion, the President's Council on Physical Fitness and Sports, the Office of Minority Health, the Office on Women's Health, the Office for Human Research Protections, the Office of Research Integrity, the National Vaccine Program Office, the Office of Military Liaison and Veterans Affairs, and the Regional Health Administrators. As a result, OPHS is actively engaged in a broad array of activities that support and facilitate the work of many of the Department's Operating Divisions.

OPHS directly supports several of the Secretarial Initiatives, such as preventing disease and ensuring our homeland is prepared to respond to acts of bioterrorism and other health emergencies. In its leadership role, OPHS ensures a public health perspective on all other Secretarial initiatives and the President's Management Agenda.

President's and Secretary's Priorities

Strategic Management of Human Capital

Consistent with the President's workforce planning and restructuring initiative, the Office of Public Health and Science has achieved a cost savings from consolidating administrative functions and implementing other effective workforce planning and human capital management strategies.

One such strategy is the review of positions to facilitate career growth and pathways. OPHS has given particular attention to entry-level and other positions at the lower grade levels. Among the avenues under consideration for career development and professional growth opportunities is an organized system of rotational assignments to promote the development of skill sets so that personnel will have the ability to the function across organizational boundaries or in other positions in an intra-office context.

Because of OPHS's wide-ranging activities, it must be prepared to respond to changes in mission with an adaptable and flexible workforce. A workforce which combines an appropriate set of skills, such as in medicine and the other health sciences, public health, policy analysis, and information technology is the key to an operational, flexible, and functional future.

In looking to the future, OPHS is continuing to plan for long term changes in both mission and manpower requirements. OPHS is also looking at the issues related to re-structuring to achieve both immediate improvements in the use of human capital, and to put in place a process for the long-term which will produce a more flexible, adaptable organizational structure.

Improved Financial Performance

In an effort to make more timely and informed decisions regarding its operations, OPHS is supporting the implementation of the HHS Unified Financial Management System (UFMS). Although OPHS' financial services are provided by the Program Support Center, OPHS has provided recommendations regarding what is needed in the system and how these systems can support day-to-day operations.

Expanded Electronic Government

OPHS has a history of leadership in the area of health information. It has also taken steps to effectively use emerging technologies to achieve positive behavior changes and minimize the burden on both public and private-sector colleagues.

The Office of Disease Prevention and Health Promotion (ODPHP) has developed, and will continue to maintain and enhance, *healthfinder* – the Federal government's consumer health information Web portal that receives nearly 6 million visits a year. ODPHP will also continue to produce authoritative reports on the use of the Internet for health improvement. As States, associations, foundations and others undertake efforts to implement *Healthy People 2010*, they need to communicate with, and learn from, each other. By facilitating web-based communications, ODPHP will assist the process of sharing best practices, outlining areas of collaboration, and exchanging new information.

The ASH is also showcasing best practices in public health from around the country, to foster an environment of peer learning and collaboration. The *Best Practice Initiative* can be found on the OPHS website at www.osophs.HHS.gov/ophs/bestpractices

OPHS is also furthering efforts to make applying for an OPHS grant friendlier, through the use of the Internet. OPHS is continuing to pursue E-grants – the ability to replace paper processes with electronic processing across the grants life cycle. The E-grants initiative will make a unified, simplified, single set of processes available to potential applicants, applicants, and awardees.

Budget Performance Integration

OPHS has revamped its GPRA Performance Plan and positioned itself to ensure that resources are tied to outcomes goals and program effectiveness. The improved plan is streamlined, and sets forth goals and output targets that assist in integrating planning and budget efforts.

Ensuring our Homeland is Prepared to Respond to Acts of Terrorism and Other Health Emergencies

OPHS continues to address the complex issues of health and medical response to emergencies, including the continued infrastructure for a medical response to terrorism of any type – nuclear, biological, or chemical – and other natural disasters and emergencies. OPHS is an integral part of the Administration's efforts to strengthen the public health system.

The Secretary has put forth a vision of strengthening the public health system, and empowering State and local efforts in a way that adds real value to the efforts of emergency resources when necessary. To support this vision, the Office of the Surgeon General (OSG) is developing an initiative to ensure national medical readiness through transforming and modernizing the Commissioned Corps.

The Medical Reserve Corps (MRC) was assigned to OSG in March 2002. The MRC is a component of the Citizen Corps, USA Freedom Corps, announced by the President in his January 2002 State of the Union address. Health professionals and others with relevant skills are being offered the opportunity to volunteer their time and skills within a local MRC during times of emergency. Volunteers can also serve in their communities addressing on-going public health needs (e.g., immunizations; health and nutrition education).

The National Vaccine Program Office (NVPO) is developing a strategy to prepare our country to respond to an influenza pandemic. There is no simple answer to the question of how serious a pandemic might be; it will depend on how virulent the virus is, how rapidly it can spread between populations, and the effectiveness of pandemic prevention and response efforts. The 1918 Spanish flu is an example of a worst-case scenario, because the strain was highly contagious and quite deadly; that pandemic killed more Americans than all the wars of the 20th century. Good surveillance, timely vaccine development and production, and the ability to administer vaccines to large numbers of people in a short amount of time will be crucial to containing such a pandemic if and when one eventually strikes.

Preventing Disease, Illness and Injury, with Particular Focus on the Healthy Communities Initiatives, and Preventing Diabetes, Obesity and Asthma

Healthy and productive individuals, families, and communities are the very foundation of a nation's security and prosperity. Through leadership in medical sciences and public health, and as guardian of critical components of America's health and safety net programs, HHS seeks to improve the health and well-being of people both in this country and throughout the world. To ensure a healthier America, OPHS plays a significant role in the development and implementation of this priority.

ODPHP will also continue to reach out to non-traditional public health partners. The goal is to identify organizations that have national leadership and local representation, including campus aged youth, faith-based organizations, and elderly service organizations. These outreach efforts can focus the public's attention on those health issues that impact on the quality of life in the US.

For all the medical breakthroughs seen in the past century, there are still significant disparities in the medical conditions of racial groups in this country. The Office of Minority Health (OMH) has made a commitment to eliminate – not just reduce – some of the health disparities between majority and minority populations. OMH will continue to develop and coordinate minority initiatives across HHS and other Federal departments. OMH will broaden and strengthen its partnerships with: State, local, and tribal governments; national and regional minority health and other minority-focused organizations; and minority community-based organizations with the greatest access to and knowledge of racial and ethnic minority communities.

HHS recently released *Women's Health USA 2002*, a statistical report on the health status of America's women that shows the disproportionate impact that certain health conditions such as osteoporosis, asthma, diabetes and lupus have on women. The Office on Women's Health will continue efforts to improve the health of American women by advancing and coordinating a comprehensive women's health agenda throughout HHS.

The issue of adolescent sexual activity and pregnancy remains a national public health concern, both within the context of welfare reform and in realizing the optimum potential of the country's youth. More than 12 percent of teen women aged 15-19 become pregnant each year, resulting in approximately 500,000 births. The costs of such premature pregnancy and parenthood are enormous. Through its AFL program, OPHS will continue efforts to evaluate abstinence education strategies, as well as services to improve outcomes for pregnant and parenting teens.

The CDC recently announced a new study finding that public health problems associated with obesity among the nation's youth are causing a major economic health care burden, in addition to having a profound effect on individual health. In response, Secretary Thompson has called on families, communities and businesses to work together and create innovative ways to encourage greater physical activity among children. The President's Council on Physical Fitness will play a major role in the efforts to develop a national action plan on physical activity.

OFFICE OF PUBLIC HEALTH AND SCIENCE

	FY 2002		FY 2003		FY 2004	
	<u>Actual</u>		<u>President's Budget</u>		<u>Estimate</u>	
	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>
<u>GDM:</u>						
Immediate Office	48	\$7,664,000	51	\$8,271,000	51	\$8,307,000
Office of HIV/AIDS Policy	6	919,000	6	989,000	6	994,000
Adolescent Family Life	17	28,924,000	18	31,124,000	18	31,241,000
Office of Disease Prevention and Health Promotion	25	7,048,000	25	7,589,000	25	7,620,000
President's Council on Physical Fitness and Sports	8	1,136,000	8	1,223,000	8	1,230,000
Office of Minority Health	68	49,546,000	69	46,329,000	69	47,010,000
Office on Women's Health	50	26,738,000	52	28,795,000	52	28,908,000
Office for Human Research Protections Transformation of the Commissioned Corps	35	7,015,000	39	7,554,000	39	7,587,000
Commissioned Corps Readiness Force	4	1,200,000	6	1,300,000	6	1,287,000
Surgeon General Initiatives	-	998,000	-	1,000,000	-	-
Subtotal, GDM	261	\$131,188,000	274	\$134,174,000	274	\$139,184,000
<u>Counter-Terrorism¹:</u>						
Medical Reserve Corps	-	\$3,000,000	2	\$10,000,000	2	\$10,000,000
<u>Other:</u>						
Reimbursable FTE	9	-	9	-	9	-
Service and Supply Fund	29	-	28	-	28	-
Office of Research Integrity ²	29	[6,935,000]	29	[7,635,000]	29	[7,974,000]
Subtotal, Other	67	-	66	-	66	-
Total, OPHS	328	\$134,188,000	342	\$144,174,000	342	\$149,184,000
[1% Evaluation Funds; non-add]		[\$4,552,000]		[\$4,552,000]		[\$4,552,000]

¹ Funds appropriated in the Public Health and Social Services Emergency Fund.² ORI is funded by NIH dollars, which are reflected as non-add.

OPHS IMMEDIATE OFFICE

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$7,664,000	\$8,271,000	\$8,307,000	+\$36,000
FTE	48	51	51	-

Purpose and Method of Operations

The Office of Public Health and Science (OPHS) is under the direction of the Assistant Secretary for Health (ASH), who serves as the Senior Advisor to the Secretary on issues of public health and science. The Immediate Office serves as the focal point for leadership and coordination across the Department in public health and science, provides direction to program offices within OPHS, and provides advice and counsel on public health and science issues to the Secretary.

The Office of the Surgeon General (OSG) is located within the Immediate Office of the ASH. The role of the Surgeon General is to protect and advance the health of the nation. The SG, who reports to the ASH, provides a highly recognized symbol of national commitment to protecting and improving the public's health, communicates with the American people on issues related to health and advises on health related behaviors and interventions.

The Immediate Office and OSG directly support several of the Secretary's Initiatives, such as the medical response to emergencies, mental health, and the Prevention Initiative. In its leadership role, the Immediate Office ensures a public health perspective on all other Secretarial and Presidential priorities. The Immediate Office provides leadership to and oversight of the OPHS program offices as they implement their programs and other HHS and Presidential priorities.

Healthy People 2010. Under the leadership of the ASH and Office of Disease Prevention and Health Promotion (ODPHP), *Healthy People 2010* (HP2010) was released by the Department on January 25, 2000. HP2010 identifies 467 specific objectives covering a comprehensive array of health issues. Using HP2010 as a framework, OPHS will provide leadership as HHS implements the Secretary's Prevention Initiative, an initiative which complements the President's *Healthier US* Initiative.

Blood Safety. As the Blood Safety Director for HHS, the ASH is responsible for the Federal government's efforts to maintain the safety of the nation's blood supply. At a recent meeting of the Advisory Committee on Blood Safety and Availability, which is coordinated by OPHS, the principles that have been articulated by the American Association of Blood Banks Inter-organizational Task Force on Domestic Disasters and Acts of Terrorism were endorsed. Examples of these principles include: the actual medical need for blood should drive all

subsequent decisions and actions in responding to acts of terrorism; the blood community should avoid creating supply in excess of medical need at the Local Blood Center(s); and the blood community response to domestic disasters and acts of terrorism should be effectively coordinated with all stakeholders.

Vaccines Issues. OPHS successfully developed responses to respond to delays in the supply of influenza vaccine, and played a critical role in negotiations for the smallpox vaccine and discussions surrounding the HHS response to anthrax. OPHS recently lead the development of a strategy to prepare the US to respond to an influenza pandemic. The fundamental concept of the Pandemic Influenza Action Plan is that certain preparations must begin now, during the current inter-pandemic grace period.

Surgeon General's Reports. A number of Surgeon General's reports have been released in the last several years: Women and Smoking (2001), Youth Violence (2001), Oral Health in America (2000), Reducing Tobacco Use (2000), and Mental Health (1999). These reports have focused the Nation's attention on important public health issues, heightened America's awareness, and generated major public health initiatives.

The Immediate Office will continue to provide leadership and oversight of the OPHS program offices as they implement the OPHS Performance Plan and priorities. The ASH and OSG will provide leadership in promoting special Departmental health priorities, e.g., bioterrorism, public health preparedness, and HIV prevention efforts. The ASH will also provide leadership for the development of policy on population-based public health and science, and on the implementation of select priorities that cut across agencies.

In partnership with the Office of Intergovernmental Affairs and the Regional Health Administrators, the ASH will also promote relationships between State and local health departments, academic institutions, professional and constituency organizations, and HHS. In addition, the ASH and the SG will communicate and interact with national and international professional and constituency organizations on matters of public health and science.

OPHS will also work with the OPDIVs and STAFFDIVs to coordinate projects that improve and strengthen the public health infrastructure in the US, through partnerships with State and local health authorities. Finally, OSG will develop and disseminate Surgeon General's Reports and authoritative statements on critical public health topics.

Rationale for the Budget Request

The FY 2004 request for the Immediate Office is \$8,307,000, a net increase of \$36,000 above the FY 2003 President's Budget. This level includes cost savings from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies. This level will allow the Immediate Office to maintain essentially the same level of activity as in FY 2003.

OFFICE OF HIV/AIDS POLICY

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$919,000	\$989,000	\$994,000	+\$5,000
FTE	6	6	6	—

Purpose and Method of Operations

The mission of the Office of HIV/AIDS Policy (OHAP) is twofold: to advise the Secretary, Deputy Secretary, and Assistant Secretary for Health (ASH) on policies, programs and activities concerning HIV/AIDS, and to coordinate HIV-related policies, activities, programs and information dissemination throughout the Department and other Federal offices and agencies within the Administration.

The Secretary has delegated to the ASH responsibility for coordinating, integrating and directing the Department's policies, programs and activities related to HIV/AIDS. A primary focus of OHAP is addressing issues related to health disparities in HIV/AIDS identified in the Congressional Black Caucus/ HHS Initiative.

OHAP support will include providing the ASH and other Departmental senior staff, including OPDIV and STAFFDIV Heads, with appropriate and timely recommendations on HIV/AIDS policy options and program initiatives. OHAP will lead the central coordination essential for the desired outcomes at the OPDIV and STAFFDIV levels. This coordination and policy function impacts upon the development of priorities for the Department in the areas of HIV/AIDS consistent with the ASH, Secretary's and Administration's priorities ensuring a comprehensive national response to the HIV/AIDS epidemic. OHAP supports the Deputy Secretary in the Department-wide HHS Coordinating Group on HIV/AIDS and leads the Steering Committee on Implementation and Evaluation of the Minority HIV/AIDS Initiative.

In June 2002, HHS established the HIV/AIDS Management Coordination Team. This team is charged with the task of improving the coordination of HIV/AIDS activities across the Department, evaluating the effectiveness of HHS's HIV/AIDS programs on an on-going basis, and improving the HIV/AIDS grants management system to achieve cost efficiencies. The Team is co-chaired by the ASH and the Assistant Secretary for Planning and Evaluation (ASPE). OHAP will play an advisory role in the overall process, and will work closely with ASPE on evaluation and recommendation activities. One area includes coordinating the Administration's efforts to eliminate health disparities in racial, ethnic minority communities – the HIV/AIDS in Minority Communities Initiative, which includes coordinating efforts with the Congressional Black Caucus, Hispanic Caucus and Women's Caucus. Activities include expanded technical

assistance efforts to communities in the US and its territories, and internal Department-wide assistance to the OPDIVs.

OHAP will continue to monitor the implementation of the Department's HIV/AIDS strategic plan for the prevention and treatment of the HIV disease. Activities will include conducting periodic regional meetings to engage consumers, providers, advocates and researchers in a dialogue about evolving priorities and emerging directions for the Department's HIV/AIDS efforts. OHAP will also continue the implementation, in collaboration with the White House, Department of Education, Department of Labor, and National organizations a special Presidential initiative on HIV-related workplace issues.

In an effort to facilitate an increased AIDS knowledge base of OPHS staff and other interested parties, OHAP will develop a series of presentations for senior staff, scientists, and others in disciplines including: therapeutics, vaccines epidemiology and natural history, prevention for HIV uninfected and HIV infected people, and care challenges in provisions of services and international. OHAP will also facilitate the programmatic development and collaboration in the context of emerging HIV/AIDS issues among STAFFDIVs and OPDIVs. OHAP will continue and strengthen communication and linkages with national HIV/AIDS organizations, as well as the various regional, State and local level constituency groups and organizations, and will also continue to provide staff support to the Office on Women's Health related to analysis and recommendations on HIV/AIDS issues for the Secretary's consideration.

Rationale for the Budget Request

The FY 2004 request for Office of HIV/AIDS Policy is \$994,000, a net increase of \$5,000 above the FY 2003 President's Budget. This level includes cost savings from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies. This level will allow OHAP to maintain essentially the same level of activity as in FY 2003.

**OFFICE OF POPULATION AFFAIRS/
ADOLESCENT FAMILY LIFE**

	FY 2002	FY 2003	FY 2004	Increase or
	<u>Actual</u>	<u>President's Budget</u>	<u>Estimate</u>	<u>Decrease</u>
Budget Authority	\$28,924,000	\$31,124,000	\$31,241,000	+\$117,000
FTE	17	17	17	—

Purpose and Method of Operations

The Adolescent Family Life (AFL) program, authorized in 1981 under title XX of the Public Health Service Act, is administered and directed by the Office of Population Affairs. AFL provides a comprehensive, innovative and integrated approach to the delivery of care services for pregnant and parenting adolescents, and prevention services that promote abstinence from sexual activity among unmarried teens.

The AFL program supports two types of demonstration programs: (1) prevention demonstrations to develop and test curricula that provide abstinence education designed to encourage adolescents to postpone sexual activity, and (2) care demonstrations to develop and test interventions with pregnant and parenting teens in an effort to ameliorate the effects of too-early childbearing for teen parents, their babies and their families. The AFL program also provides support for research projects into the causes and consequences of adolescent premarital sexual relations, adolescent pregnancy and parenting.

The AFL program supports the Administration priorities of promoting abstinence education and eliminating racial and ethnic disparities in health by ensuring a healthy start for all children. The AFL prevention projects stimulate the development and implementation of programs to encourage adolescents to choose abstinence.

Rationale for the Budget Request

The FY 2004 request for AFL is \$31,241,000, a net increase of \$117,000 above the FY 2003 President's Budget. This level includes a cost savings from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies.

This funding level will enable the AFL program to continue ongoing abstinence education projects to pre-adolescents and adolescents, both male and female, with the message that abstinence is the most effective means of preventing pregnancy. These projects will focus on

postponing sexual activity to prevent adolescent pregnancies and repeat pregnancies as well as Sexually Transmitted Diseases (STDs) and HIV/AIDS. These projects will concentrate on reducing other health risks among pre-adolescents and adolescents, such as tobacco, alcohol, drugs and violence. Additionally, these prevention projects teach adolescents refusal skills and use age appropriate educational materials that emphasize and promote the abstinence message.

The AFL program will continue ongoing efforts to provide services to pregnant and parenting teens, their infants and families, partners, as well as emphasize the prevention of repeat pregnancies, focus on education to reduce the incidence of STDs and HIV/AIDS and the continuation of education, safe housing, job placement, adolescent health behaviors, including smoking, alcohol, substance abuse and violence as well as on services to young fathers.

The AFL program will continue its technical assistance training efforts to all management and front-line staff of existing grantees. This training will provide the management and front line grantee staff with current knowledge of program requirements, and recent findings on pregnancy prevention in adolescent and STD and HIV prevention activities. These training efforts further fine tunes the skills of management and front line grantee staff to conduct more effective programs.

ADOLESCENT FAMILY LIFE

Program Data

	FY 2002 <u>Actual</u>		FY 2003 <u>Estimate</u>		FY 2004 <u>Estimate</u>	
	<u>No.</u>	<u>Amount</u>	<u>No.</u>	<u>Amount</u>	<u>No.</u>	<u>Amount</u>
PROGRAM FUNDING:						
Demonstration Grants (Title XX):						
-Prevention (Abstinence)	1	\$220,000	5	\$1,000,000	5	\$1,000,000
-Care	46	12,870,000	50	14,063,000	50	14,063,000
Subtotal, Demo Grants	47	13,090,000	55	15,063,000	55	15,063,000
Prevention -Title V: Welfare Reform (Abstinence):						
-Pilot Projects	0	0	0	0	0	0
-Demonstration Projects	55	11,800,000	55	11,800,000	55	11,800,000
Subtotal, Welfare Reform	55	11,800,000	55	11,800,000	55	11,800,000
Research/Agreements/TA	3	1,808,000	4	1,808,000	4	1,808,000
-Subtotal	105	\$26,698,000	114	28,671,000	114	28,671,000
Support Costs		2,226,000		-2,453,000		-2,570,000
TOTAL		\$28,924,000		\$31,124,000		\$31,241,000
Total Abstinence Prevention - Titles V & XX (non-add)	56	(\$12,020,000)	60	(\$12,800,000)	60	(\$12,800,000)
CLIENTS SERVED:						
Demonstration Grants:						
-Prevention	1	2,214	5	11,071	5	11,071
-Care	46	25,220	50	27,400	50	27,400
-Prevention/Care	-0	-0	-0	-0	-0	-0
- Subtotal	47	27,434	55	38,471	60	38,471
Prevention (Welfare Reform):						
-Pilot Projects	—	—	—	—	—	—
-Demonstration Projects	55	74,800	55	74,800	55	74,800
	102	102,234	110	113,271	115	113,271

Grants are awarded at the end of the fiscal year; therefore, clients receive services in the next fiscal year. The "Client Served" data reflect the number of clients service utilizing the respective fiscal year funds, which is typically dispersed during the following year.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$7,048,000	\$7,589,000	\$7,620,000	+\$31,000
FTE	25	25	25	—

Purpose and Method of Operations

The Office of Disease Prevention and Health Promotion (ODPHP) provides leadership, coordination and policy development for public health and prevention activities within OPHS. Its central mandates are to assist the ASH and OS in:

- Coordinating health promotion and disease prevention activities, especially those related to the President's *Healthier US* initiative, the Secretary's *Steps to a Healthier US* initiative, and *Healthy People 2010*.
- Developing and promoting innovative approaches to communicating health information, as part of the emerging national health information infrastructure; and
- Addressing cross-cutting public health issues in public health and science.

ODPHP coordinates *Healthier US* and *Steps to Healthier US* on behalf of the Department. Together, these initiatives focus both on preventing disease by addressing major risk factors (such as physical inactivity and poor nutrition) and on reducing the burden of disease through appropriate health screenings and prevention of secondary conditions. The Secretary's initiative will have a special emphasis on diabetes, obesity, and asthma. ODPHP also coordinates the implementation of *Healthy People 2010*. *Healthy People 2010* (HP) supports the President's *Healthier US* initiative by offering specific goals across a range of health areas. Through concrete objectives and measurable targets, it provides a framework for programs necessary to achieve the President's vision.

A key component of ODPHP's mission is to provide leadership in consumer health information, with an emphasis on coordinated approaches with the public health and health care communities. ODPHP manages www.healthfinder.gov, the Federal government's award-winning health information portal, which provides the public with the Internet-based information necessary to make informed health-related decisions. ODPHP provides lead staff for HHS-wide committees examining the emerging national health information infrastructure. Underlying all of ODPHP's activities are the scientific and technical staff necessary to carry out its mandate. ODPHP must have sufficient scientific, medical, public health and technical capacity to adequately support the

Administration's health promotion and disease prevention activities, priorities and programs. Examples of ODPHP's accomplishments over the last several years include the following:

In FYs 2001-2002, ODPHP developed and signed six Memorandum of Understanding (MOU) partnerships regarding HP. The significance of these MOUs is that the board of directors or house of delegates of each organization has passed a resolution to support HP 2010, adopt 2010 objectives or embrace HP as a strategic plan, and is now formally working with the Department to achieve the HP 2010 goals. In FYs 2003 and 2004, up to six new MOUs will be developed in support of *Healthier US* and *Steps to a Healthier US*. In FY 2001, ODPHP provided micro-grants to two intermediaries (North Carolina and Connecticut) to provide small grants to communities for the purpose of demonstrating community involvement in implementation and achieving HP goals and objectives. To date, more than 200 local groups have been scheduled for funding. Results from evaluations of these pilot programs will be available in FYs 2003 and 2004. Preliminary feedback is very promising.

In FY 2002, ODPHP has initiated *Healthy People 2010* progress reviews to engage the ASH, lead agencies, and other Federal agencies in a dialogue on HP 2010 progress, challenges, and strategies. These will continue in FYs 2003 and 2004. ODPHP also convened State *Healthy People* coordinators to share successful experiences in implementing HP at the State level and identify common concerns and solutions.

In FY 2001-02, ODPHP led the development and release of the Surgeon General's Call to Action on Overweight and Obesity, establishing this issue as the leading public health challenge. In FY 2003 and 2004, ODPHP will strengthen partnerships around these issues as part of its support for *Healthier US*. It will also lead the interagency effort to develop the next *Dietary Guidelines for Americans*.

In FY 2002, in conjunction with a wide range of external experts, ODPHP developed *Communicating Health*, a set of action plans for achieving the Healthy People 2010 objectives for health communication. In FY 2003 and 2004, ODPHP will convene stakeholders to implement these plans.

In FY 2002, ODPHP led the staff of the National Committee on Vital and Health Statistics Workgroup on the National Health Information Infrastructure (NHII) and published the Workgroup's report, *Information for Health: a Strategy for building the national health information infrastructure*. In 2003 and 2004, ODPHP will work to strengthen the prevention component of the NHII activities.

In FY 2002, the Deputy Secretary launched ODPHP's new Internet resources for American Indians and Alaska Natives on the award-winning *healthfinder.gov* Web site in recognition of Native American Heritage Month. In FY 2003, ODPHP will develop similar special resources for Asian Americans and Pacific Islanders for Asian American Heritage Month.

Rationale for the Budget Request

The FY 2004 request for ODPHP is \$7,620,000, a net increase of \$31,000 above the FY 2003 President's Budget. This level includes cost savings from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies. This level will allow ODPHP to maintain essentially the same level of activity.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

Program Data

Activity	FY 2002 Actual	FY 2003 Pres Budget	FY 2004 Estimate	Change
HEALTHY PEOPLE AND COMMUNITIES 1/				
<i>Healthier US</i> outreach, coordination; HP coordination	\$915,000	\$1,000,000	\$1,000,000	-
LHI Reviews and Annual Report	100,000	-	-	-
Other (personnel, overhead, expenses)	1,790,560	2,219,560	2,236,560	+17,000
<i>Subtotal</i>	<i>2,805,560</i>	<i>3,219,560</i>	<i>3,236,560</i>	<i>+17,000</i>
PREVENTION COMMUNICATION				
<i>healthfinder</i> , other websites, NHIC 2/	1,650,000	1,650,000	1,650,000	-
Communication Support Contract	642,000	710,400	710,400	-
Other (personnel, etc.)	842,520	884,520	891,520	+7,000
<i>Subtotal</i>	<i>3,134,520</i>	<i>3,244,920</i>	<i>3,251,920</i>	<i>+7,000</i>
NUTRITION, CLINICAL AND ENVIRONMENTAL HEALTH:				
Luther Terry Fellow 3/	200,000	200,000	200,000	-
Scientific updates, incl. <i>Dietary Guidelines for Americans</i> 4/	30,400	-	-	-
Other (personnel, etc.)	877,520	924,520	931,520	+7,000
<i>Subtotal</i>	<i>1,107,920</i>	<i>1,124,520</i>	<i>1,131,520</i>	<i>+7,000</i>
TOTAL	\$7,048,000	\$7,589,000	\$7,620,000	+\$31,000

Text Notes

- 1/ Includes *Healthier US*, *Steps to a Healthier US*, *Healthy People 2010*, worksite, and communities.
- 2/ NHIC (the National Health Information Center) is a health information referral service and key support component of *healthfinder*.
- 3/ Agreement with the Association of Teachers of Preventive Medicine (FY 2001) includes health policy experience for physicians and related activities.
- 4/ *Dietary Guidelines* work will be done using evaluation set-aside funds in FY 2003.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

Workload Data

Activity	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate
Healthy People and Leading Health Indicators Implementation and Outreach	5 HP2010 Progress Reviews; 4-6 new MOUs with HP 2010 partners; co-sponsor National Public Health Week; micro-grants program continued; Leading Health Indicator national and State data produced; HP2010 State Contacts conference; HP2010 Health Communication action plans developed.	Coordinate, integrate and leverage HHS-wide prevention initiatives on behalf of President's <i>Healthier US</i> initiative and Secretary's <i>Steps to a Healthier US</i> initiative; <i>Healthier US</i> Summit; 4 new MOUs with prevention partners; 4 issues of <i>Prevention Report</i> in support of <i>Healthier US</i> ; co-sponsor National Public Health Week; micro-grants program continued; HP2010 Progress Reviews continued.	Coordinate, integrate and leverage HHS-wide prevention initiatives on behalf of the President's <i>Healthier US</i> initiative and the Secretary's <i>Steps to a Healthier US</i> initiative; <i>Healthier US</i> Summit; 2 new MOUs with non-traditional prevention partners; 4 issues of <i>Prevention Report</i> in support of <i>Healthier US</i> ; co-sponsor National Public Health Week; HP2010 Progress Review continued.
Prevention Communications, including electronic health communication	15 million Web site visits; 8 meetings; 8 technical assistance presentations; development and publication of <i>Information for Health: a Strategy for Building the National Health Information Infrastructure</i> ; special healthfinder.gov section for American Indians and Alaska Natives.	18 million Web site visits; 2 Health Communication meetings; 8 eHealth presentations; special healthfinder.gov section on Asian Americans and Pacific Islanders; enhanced <i>Healthier US</i> Website.	23 million Web site visits; 4 eHealth technical assistance presentations; health communication and eHealth stakeholders meeting; enhancements to <i>Healthier US</i> Website.

General Departmental Management

Dietary Guidelines for Americans (in FY 2004, evaluation funds will be used)		Advisory committee created and convened; 2 meetings	Committee meetings, report drafted; consumer testing of messages; final report production
--	--	---	---

PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$1,136,000	\$1,223,000	\$1,230,000	+\$7,000
FTE	8	8	8	—

Purpose and Method of Operations

Created in 1956, the President's Council on Physical Fitness and Sports (PCPFS) serves as a catalyst to promote, encourage, and motivate the development of physical activity/fitness and sports participation for all ages. PCPFS's signature program, the President's Challenge Awards Program, encourages all Americans age 6 and older to become and stay active, fit and healthy. In addition to overseeing and monitoring the President's Challenge, PCPFS works closely with individual citizens, civic groups, the private sector and other Federal and public agencies to promote and increase physical activity and fitness across the nation.

To respond to the President's *Healthier US* initiative and the Secretary's Prevention program, as well as the overweight/obesity and physical inactivity epidemics, PCPFS will play a lead role in developing a collaborative national action plan and implementation strategy, enhancing physical activity participation and evaluation.

With more than 60 percent of American adults currently overweight, the US health leadership now recognizes that increased obesity has become one of the most important public health problems facing the nation. It is estimated that the premature loss of life from overweight and obesity could soon meet or exceed the loss associated with smoking. A key prevention activity related to this epidemic disease is to increase the amount and quality of physical activity in the US, especially among youth and seniors. Increasing physical activity is a key prevention strategy related to the health consequences of heart disease (the leading cause of death in the US), certain cancers, diabetes, osteoporosis and other serious health conditions.

In conjunction with the Department's Initiative to Eliminate Racial Disparities in Health, PCPFS intends to increase outreach efforts for the President's Challenge Awards program via a free interactive website. This effort will target youth populations which are currently under-represented in the programs (i.e., inner city and home-schooled youth), as well as other at-risk populations, including seniors, disabled individuals, and those at risk of developing or currently suffering from chronic disease conditions linked with physical inactivity. PCPFS plans to design and offer technical advice on implementing programs to encourage prolonged commitment to physical activity, specifically targeting these populations. These efforts will entail increased use of Council members and professional staff for public speaking, media campaigns, other public

events, as well as high level task forces, to encourage increased adoption and maintenance of physical activity and fitness.

In FY 2002, PCPFS introduced the Presidential Active Lifestyle Award and Presidential Adult Active Lifestyle Award as part of the President's Challenge Awards Program. These activity-centered awards are noncompetitive, and can be used both within and outside organized settings by individuals of all ages.

In FY 2002, PCPFS established several new formal partnership agreements with both public and private entities that involve the creation or enhancement of initiatives aimed at increasing physical activity participation among various populations.

In FY 2003 and FY 2004, PCPFS plans to substantially increase the number and variety of Americans participating in the Presidential Awards Program, and to consolidate existing informational materials. PCPFS will enhance current efforts to collect and disseminate information about best practices in physical activity promotion.

PCPFS will also produce supplementary publications that target various audiences (children, teens, adults, seniors, people with disabilities, health conditions and health disparities) and that promote awareness and adoption of the prevention behaviors outlined in the President's *Healthier US* initiative.

PCPFS will significantly enhance its existing website, www.fitness.gov, through integration with other Federal physical activity and health resources, and will also enhance the President's Challenge website through the addition of interactive features designed to increase participation in physical activity by all audiences.

In FY 2003 and FY 2004, Council members will be called upon more frequently to expand the reach and scope of the message. Specifically, Council members will increase their public speaking engagements and expand their involvement in creating and enhancing physical activity initiatives throughout the country, to target populations where disparities or special health risks have been identified, such as those with high incidences of obesity, diabetes, heart disease and asthma. Council members will also assist in hosting a series of local events that spotlight best practices in physical activity promotion, and highlight local physical activity resources. It is anticipated that the PCPFS will hold two Council meetings per fiscal year.

Rationale for the Budget Request

The FY 2004 request for PCPFS is \$1,230,000, a net increase of \$7,000 above the FY 2003 President's Budget. This level includes cost savings from consolidating administrative functions and implementing effective workforce planning and human capital strategies. This level will allow PCPFS to maintain essentially the same level of activity.

OFFICE OF MINORITY HEALTH

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$49,546,000	\$46,329,000	\$47,010,000	+\$681,000
FTE	68	69	69	—

Purpose and Method of Operations

The Office of Minority Health (OMH) was established in statute by the Disadvantaged Minority Health Improvement Act of 1990 (PL 101-527) and reauthorized under the Health Professions Education Partnerships Act of 1998, (PL 105-392). Its role is to coordinate and monitor activities and existing policies across the HHS that relate to the following with respect to racial and ethnic minority populations: disease prevention, health promotion, service delivery, and research. It also provides national leadership in minority health; develops and implements new policies to improve minority health; partners with States and communities; develops and implements data policy; and develops and disseminates information.

Since 1986, OMH has been the Federal focal point for minority health issues in the United States. The overall mission of OMH is to improve the health status and quality of life for racial and ethnic minority populations in the US, by building local capacity for addressing health and human service problems. Therefore, OMH performs an important role in addressing the health status of American minority populations, which continues to lag behind the health status of the US population as a whole. The focus of OMH's efforts is to eliminate health disparities that disproportionately affect racial and ethnic minorities. OMH assures that health decision-makers are informed and educated about racial and ethnic health disparities and that appropriate policies and programs are developed to eliminate such disparities.

OMH's mission is thus directly related to the third theme of the HHS Strategic Plan for FYs 2003-2008, "Closing the Gaps in Health Care," specifically Objective 3.4, "Eliminate racial and ethnic health disparities." In FY 2004, OMH will continue service demonstration projects to identify difficulties in access, quality and outcomes of care and develop better strategies to improve services for racial and ethnic minority populations, including limited English-speaking individuals. OMH will also disseminate information on effective strategies for eliminating disparities identified and developed through these demonstration projects. With the requested program increases, OMH will raise awareness among minority communities about major health risks prevalent in racial/ethnic populations and provide access to information on how to reduce these risks.

To achieve Objective 3.4 and in support of the Department's Initiative to Eliminate Racial and

Ethnic Disparities in Health, OMH will continue to collaborate with HHS agencies; other Federal departments; State, local and tribal governments; and community and professional groups to address broader determinants of health such as education, environment, income and other socioeconomic factors which contribute substantially to health outcomes. OMH will broaden and strengthen its partnerships with State, local, and tribal governments; national and regional minority health and other minority-focused organizations; and minority community-based organizations that have the greatest access to and knowledge of racial and ethnic minority communities. It will also support the Department's effort to partner with minority institutions of higher education.

The program increases described below reflect the best estimates of funding levels needed by OMH to augment its existing programs, and to carry out the activities in support of the HHS strategic objective of eliminating racial and ethnic health disparities.

Major OMH activities summarized below follow the cross-cutting strategies described in the OPHS FY 2004 GPRA plan.

Improving and Influencing Policy

OMH continues to affect policies, programs and practices to address health disparities. In addition, in FY 2001, with the use of One Percent Evaluation funds, OMH completed a project to develop recommended national standards for culturally and linguistically appropriate services (CLAS) in health care. To build upon the CLAS standards, OMH initiated two new evaluation projects at the end of FY 2001 to pilot test the standards and develop cultural competency curriculum models for training health care professionals in the implementation of these standards. These projects will be completed in FY 2003, with the results to be disseminated to a wide range of health providers, health care organizations, and consumers.

OMH continued a number of activities to promote the collection of health data and the strengthening of data infrastructures, in order to enable the identification and monitoring of health status among US racial and ethnic minorities, the nature and extent of health disparities affecting them, and the effects of initiatives and interventions targeting their health problems. For example, OMH co-chairs the HHS Data Council's Working Group on Racial and Ethnic Data, the internal advisory group to the Secretary on minority health data and statistics.

In FY 2000, OMH began a review of State laws and regulations which prohibit the collection of racial and ethnic data by health insurers and HMOs in the private market. In FY 2001, Phase I of this project—involving the review of State laws, regulations, and other written policies regarding the collection of racial and ethnic data in health care—was completed. OMB's approval of the survey instrument was obtained to proceed to Phase II, which involves site visits to States for an in-depth review of State policies and practice regarding the collection, reporting and use of racial and ethnic data by health insurers and Managed Care Organizations. In FY 2003, OMH will complete site visits to 20 States. The executive summary and

recommendations will be widely distributed to representatives from national, State, and local government, private, non-profit and community-based organizations, and consumers, and be available on the OMH Resource Center (OMHRC) and related websites. The findings will be critical in clarifying State policies on collection of racial and ethnic data.

In FY 2001, OMH co-funded a comprehensive study of HHS data collection systems and practices relating to race and ethnicity data. Title III of the "Minority Health and Disparities Research Education Act" directs the Secretary to contract with the National Academy of Sciences to conduct such a study and develop a report. The study will be completed in FY 2002. OMH will be central to the dissemination of findings and identifying opportunities for the implementation of recommendations.

Also in FY 2002, OMH completed a study to develop and test a uniform information/data set (UDS) for evaluating and assessing the impacts of OMH-funded activities. The final report's executive summary, which includes technical assistance guidelines for using the UDS, will be disseminated to a wide audience and be made available on the OMHRC Website and hot-linked to other sites. In addition, an article on the UDS project was accepted for publication in the journal, *Evaluation and Program Planning*. During FY 2003, OMH plans to implement the uniform data set among the newly awarded OMH grantees and cooperative agreements. This includes the completion of the Web-based demo of the uniform data set and transitioning the UDS from the paper forms to the Web-based version. The UDS will provide data to better measure the impact of the projects on closing the gap in racial and ethnic health disparities.

Enhancing the Science Base

OMH continued in FYs 2001 and 2002 to foster service demonstration projects, evaluations, and other studies of interventions aimed at improving health and the health care system to strengthen and expand the science base for decision-making, determine model approaches and best practices, and identify and overcome barriers to health, as well as program and intervention effectiveness.

In August 2000, OMH awarded a 17-month contract to the Institute of Medicine for a study entitled *Understanding and Eliminating Racial and Ethnic Disparities in Health Care*. This study was mandated by Congress in FY 2000 appropriations report language to "assess the extent of differences in the kinds and quality of health care received by US racial and ethnic minorities and non-minorities, explore factors that may contribute to differences, and recommend policies and practices that eliminate inequities." The results of this study were released in March 2002 in a report entitled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care."

As a response to the 1999 Institute of Medicine's report, *To Err is Human: Building a Safer Health System*, and its follow-up report, *Crossing the Quality Chasm*, OMH will be conducting in FY 2003 a study of the impact of cultural and linguistic barriers on patient safety and medical

errors. This study would investigate the interface between health care quality assurance efforts relative to patient safety/medical errors reduction and the challenges posed by cultural and linguistic factors to effective physician/health plan staff-patient interactions, clinical/staff encounters, and diagnosis and treatment options. Included in this study would be a focus on how such barriers affect physician, staff, and member/patient comprehension and member/patient compliance with care and treatment regimens.

In FY 2002, OMH completed the development of a research agenda for cultural competence in health care, based on the national standards on culturally and linguistically appropriate services (CLAS) that OMH developed in 2000. In FY 2003, OMH will be completing the pilot study to identify the systems features associated with the implementation of the CLAS standards as well as a compendium of best practices of cultural competence in public hospitals and health systems and cultural competency curriculum modules for family practitioners.

In early FY 2003, OMH is expected to complete its study of culturally and linguistically appropriate services provided by managed care organizations serving racially/ethnically diverse and vulnerable populations. In addition, in FY 2002 OMH conducted a feasibility study to determine whether a similar type of study can be done at the consumer/beneficiary level.

In FYs 2001 and 2002, OMH continued to support its principal demonstration grant programs. In FY 2001, OMH funded 11 continuations and 9 new projects under the *Bilingual/Bicultural Service Demonstration Program* to improve the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health services to limited-English-proficient minority populations. These 20 projects received continuation support in FY 2002. A competitive cycle is planned for FY 2003. The *Minority Community Health Coalition Demonstration Program* supports projects that address socio-cultural barriers and demonstrate effective coordination of integrated community-based screening, outreach, and other enabling services. A competitive cycle for this program, renamed the *Community Programs to Improve Minority Health Grant Program*, was conducted in FY 2001 with 17 new awards. These projects received continuation funding in FY 2002 and will receive continuation support in FY 2003. In FY 2004, a competitive cycle is planned.

In FY 2001, OMH established the *Health Disparities Grants in Minority Health Program*. The Program supports local pilot and small-scale projects, which address a wide range of health problems and issues related to health disparities in local minority communities. A total of 30 projects were funded in FY 2001; 23 of these received continuation support in FY 2002. In addition, 20 new projects received funding in FY 2002. In addition to supporting continuing projects, competitive cycles are planned for FYs 2003 and 2004.

OMH has also continued the programs funded by the Minority HIV/AIDS Initiative. These include the *Technical Assistance/Capacity Development Demonstration Program (TA/CD) for HIV/AIDS-Related Services in Highly Impacted Minority Communities*, the *State and Territorial Minority HIV/AIDS Demonstration Program*, and the *Minority Community Health Coalition*

Demonstration Program HIV/AIDS. More than 60 organizations are involved in these partnerships. OMH conducted competitive cycles in FY 2002 for the *Technical Assistance/Capacity Development Demonstration Program (TA/CD) for HIV/AIDS-Related Services in Highly Impacted Minority Communities*, and the *Minority Community Health Coalition Demonstration Program HIV/AIDS*. In FY 2002, 12 new projects were supported under the TA/CD program, 16 under the *State and Territorial* program, and 17 under the *Coalition* program. In addition to supporting continuing projects for all three programs, a competitive cycle is planned for the TA/CD in FY 2003.

Strategic Communication

OMH has also moved to increase awareness and understanding of the major health problems and needs of racial and ethnic minorities and the nature and extent of health disparities between racial/ethnic groups in the US through a wide range of informational and educational efforts aimed at decision-makers, health professionals, those serving racial/ethnic minority communities, and the general public.

OMH extended its health promotion and communication efforts to minority consumers and the community and health service organizations working with them. During FYs 2001 and 2002, OMHRC expanded its new quarterly publication, *HIV Impact*, and its already successful *Closing The Gap* newsletter. Circulation for each publication grew from 10,000 to 40,000 for each publication by the end of 2002.

OMHRC's HIV technical assistance team conducted 11 regional skills building workshops for 175 minority community organizations in 2002, together with 45 technical assistance visits and 800 consultations with community organizations working on HIV with minority populations. In 2004, OMH expects the team to conduct regional skills building workshops reaching 300 community organizations, engage in 55 technical assistance visits and 1,500 program consultations.

Visitors to OMH's web site seeking health information grew from 340,000 in FY 2001 to 540,000 in FY 2002, and are expected to reach 900,000 by FY 2004.

In July 2002, OMH hosted the first of three "National Leadership Summits" for eliminating racial and ethnic disparities in health to take place over the current decade. The purpose of these summits is to serve as vehicles for highlighting, promoting, and applying the knowledge, experience, and expertise of hundreds of community-based organizations and partners across the Nation towards more strategic, concerted, and effective actions aimed at eliminating racial and ethnic disparities in health. More than 2,200 people attended this first summit.

In response to the State Minority Health Infrastructure Study, OMH conducted a National American Indian/Alaska Native Health Forum in September 2002. The purpose of this Forum is to identify strategies through which State, tribal, and Federal governments can complement and

supplement their respective health systems to improve the health of Native Americans, including those who are not Federally recognized, and to identify strategies for the development of a coordinated plan for elimination of health disparities impacting American Indian/Alaska Native communities. The Forum brought together approximately 300 participants.

Building Partnerships

OMH has continued to establish and strengthen networks, coalitions, and partnerships to identify and solve health problems and concerns affecting racial and ethnic minorities. Under the *State Partnership Initiative*, designed to assist State minority health entities in developing or expanding their existing infrastructure and capacity to address racial and ethnic health disparities, OMH awarded contracts to 11 States in FY 2002. These projects demonstrate best practices and innovative ways to address health disparities at the State and local levels.

In 2003, OMH will include projects to help improve State public health entities' ability and capacity for communicating and working with various racial and ethnic minority community organizations to develop and communicate disaster and emergency preparedness plans. OMH will also conduct regional multicultural coalition-building workshops for State offices of minority health to address the growing racial/ethnic minority populations and the increasing disparities in health care among the racial/ethnic groups that the States serve.

In FY 2001, in collaboration with the Office of the Assistant Secretary for Public Affairs, OMH initiated a new partnership with the ABC Radio Networks and ABC Radio's Urban Advantage Network to begin planning "Closing the Health Gap," a campaign to bring the best HHS health information to African American consumers and radio listeners. Announced in November 2001, the partnership produced and aired broadcast health messages on ABC's Urban Advantage Radio Network and programs including the Tom Joyner Morning Show throughout FY 2002. Messages were heard on 250 broadcast stations across the country. HHS and ABC sponsored the first national Take A Loved One to the Doctor Day in September 2002, with events in all ten HHS regions. In fiscal years 2003 and 2004, HHS intends to work with various broadcast partners to expand the Closing the Health Gap campaign to Hispanic and other minority audiences and expand Take a Loved One to the Doctor Day activities to more communities. OMH expects broadcast health messages to be aired on as many as 500 media outlets.

Lead and Coordinate Key Initiatives

OMH established an effective mechanism for coordinating the various HHS minority initiatives through the Departmental Minority Initiatives Coordinating Committee (DMICC), which the Deputy Assistant Secretary for Minority Health chaired. The DMICC served as the coordinating body for the Historically Black Colleges and Universities Initiative, the Hispanic Agenda for Action, the Tribal Colleges and Universities Initiative, and the Asian Americans and Pacific Islanders Initiative. In FY 2003, OMH intends to re-constitute a Department-level coordinating committee for minority health and health disparities.

During FY 2002, the Deputy Assistant Secretary for Minority Health led an effort to identify key agency activities for the elimination of racial/ethnic health disparities that could be replicated, would build partnerships in HHS, and which will show tangible results in the near future. Plans are being developed and finalized for infant mortality and diabetes. In subsequent fiscal years, the OMH will continue to coordinate focused and intensified Departmental strategies aimed at closing the gaps that exist by race and ethnicity for all groups in the six priority health issue areas (infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and child/adult immunizations) of the HHS Initiative. Press releases and national efforts towards eliminating racial and ethnic health disparities will continue in a timely fashion.

Rationale for the Budget Request

The FY 2004 request for OMH is \$47,010,000, a net increase of \$681,000 above the FY 2003 President's Budget. This level includes a cost savings from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies.

The FY 2003 President's Budget included \$500,000 for a one year study, Study of the Impact of Cultural and Linguistic Barriers on Patient Safety and Medical Errors, to investigate and highlight the connection between health care quality assurance efforts and challenges and barriers posed by communication and linguistic factors. Funds for this study are not required in FY 2004.

Health Disparities Campaign. OMH is requesting \$300,000 for a national Hispanic media campaign to increase awareness of the health disparities between majority and minority populations in the US, and steps consumers can take to assume control of their health. Building on our already successful national radio partnership, *Closing The Health Gap*, the campaign will focus on the nationwide lack of awareness of health disparities between US majority and minority populations. Funds would expand the *Closing the Gap* broadcast campaign to focus on the Hispanic population in order to: increase the public's knowledge of existing disparities; increase their willingness to contact and utilize the HHS agencies for their health concerns; educate them regarding steps that can be taken to improve their health; and increase their awareness of HHS health information and HHS-funded services. The principal medium utilized would be radio, with support from campaign websites and a small number of local health events where appropriate.

Office of Minority Health Resource Center. An increase of \$200,000 will enable OMH to enhance the operations of the OMH Resource Center (OMHRC) and its ability to provide technical assistance to OMH grantees and other minority community organizations. This increase will also allow OMH to begin delivering educational programming on-line for HIV and other critical health disparities. Funds will help OMHRC handle an increased demand for regional and on-site HIV/AIDS technical assistance to minority community organizations, including those in rural areas and for outreach to faith-based organizations. HIV technical

assistance will follow trends in the epidemic (organizations serving youth/adolescents; minority women, especially young women and female partners of HIV drug users; men who have sex with men; and men who have sex with both men and women). It will be directed to community groups and geographic areas in which the HIV epidemic is not receiving sufficient attention (e.g. rural areas, faith-based efforts).

OFFICE OF MINORITY HEALTH

Program Data

Activity	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Change
CONTRACTS:				
OMH Resource Center	\$2,200,000	\$2,200,000	\$2,400,000	+200,000
Logistical Support Contract	900,000	900,000	900,000	—
Center for Linguistic and Cultural Competency in Health Care (CLCCHC)	1,900,000	1,900,000	1,900,000	—
Health Disparities Campaign	—	—	300,000	+300,000
Male Health Project	1,000,000	1,000,000	1,000,000	—
Study of the Impact of Cultural and Linguistic Barriers on Patient Safety and Medical Errors	—	500,000	—	(500,000)
Other Contracts and Interagency Agreements	1,600,000	1,600,000	1,600,000	—
Subtotal, Contracts	7,600,000	8,100,000	8,100,000	—
COOPERATIVE AGREEMENTS:				
Family and Community Violence Prevention Program	7,400,000	7,400,000	7,400,000	—
Meharry Medical Center	1,000,000	1,000,000	1,000,000	—
HIV/AIDS Cooperative Agreements	2,800,000	2,800,000	2,800,000	—
Other Cooperative Agreements	1,500,000	1,500,000	1,500,000	—
Subtotal, Coop Agreements	12,700,000	12,700,000	12,700,000	—
DEMONSTRATION PROJECTS:				
Community Programs to Improve Minority Health (formerly Minority Community Health Coalition Projects)	2,500,000	3,000,000	3,000,000	—
Minority Community Health Coalition Projects - HIV/AIDS	2,500,000	2,500,000	2,500,000	—
Bilingual/Bicultural Demonstration Projects	2,950,000	2,950,000	2,950,000	—

General Departmental Management

Activity	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Change
State and Territorial Minority HIV/AIDS	2,500,000	2,500,000	2,500,000	—
Regional Resource Networks	—	—	—	—
(CBC AIDS - Non-add)	(1,300,000)			
Health Disparities Grants	2,200,000	2,390,000	2,390,000	—
State Partnership Initiative Grant Program (formally shown under Contracts)	1,000,000	2,500,000	2,500,000	—
Technical Demonstration Program for HIV/AIDS	200,000	200,000	200,000	—
(CBC AIDS - Non-add)	(6,600,000)			
San Francisco Department of Public Health (HIV/AIDS)	650,000	—	—	—
Access Community Health Network	100,000	—	—	—
AIDS Foundation of Chicago	500,000	—	—	—
Baltimore City Health Department (HIV)	500,000	—	—	—
Cleveland Clinic Foundation	2,000,000	—	—	—
County of San Diego	200,000	—	—	—
Glaucoma Caucus Foundation	500,000	—	—	—
Padres Contra El Cancer	200,000	—	—	—
Sisters Network, Inc	150,000	—	—	—
Thomas Jefferson University Hospital	1,500,000	—	—	—
University of Medicine and Dentistry	200,000	—	—	—
Subtotal, Demonstrations ..	20,350,000	16,040,000	16,040,000	—
Secretarial Priorities	—	282,000	453,000	+171,000
Operating Expenses	8,896,000	9,207,000	9,717,000	+510,000
TOTAL, Budget Authority	\$49,546,000	\$46,329,000	\$47,010,000	+\$681,000
Non-HIV/AIDS	37,509,748	35,668,223	36,304,359	+636,136
HIV/AIDS	12,036,252	10,660,777	10,705,641	+44,864
(CBC AIDS - Non-add)	(7,900,000)			

OFFICE OF MINORITY HEALTH

Workload Data

	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate
Community Programs to Improve Minority Health: (formerly Minority Community Health Coalition Projects)			
Number of Grants	17	21	21
Number of People Served	21,952	27,111	27,111
Bilingual/Bicultural Service Demonstration Projects:			
Number of Grants	20	23	23
Number of People Served	31,401	31,473	31,473
Family and Community Violence Prevention Program:			
Number of Cooperative Agreements	1	1	1
Number of People Served	6,292	6,534	6,534
HIV Activities in Minority Communities:			
Number of Grants	32	34	34
Number of People Served	47,707	50,689	50,689
Health Disparities:			
Number of Grants	41	45	63
Number of People Served	18,942	20,328	28,464
Regional Resource Network:			
Number of Cooperative Agreements	1	1	1
Number of People Served	1,250	1,500	1,500

* Includes 15 projects that provide services to community-based organizations, rather than individuals.

NOTE: Awards are issued at the end of the fiscal year. Number of people projected will actually be provided services in the following fiscal year.

General Departmental Management

OMH RESOURCE CENTER			
	2002	2003	2004
Projections for Inquiries:			
Telephone and Conferences/Mail	10,000	11,000	12,000
Mail	1,500	300	300
Electronic Mail	-2,500	3,000	3,800
Total	14,000	14,300	16,100
- World Wide Web			
-Hits Web	2,700,000	3,200,000	3,700,000
-Visits Web	540,000	-700,000	-900,000
Projections for Service Deliveries:			
Regional Skill Building Meetings:			
No.	10	—	12
Attendance	175	—	240
Organizations Receiving:			
Technical Assistance	108	135	160
On Line Courses:			
Newsletter	250,000	400,000	400,000
Exhibit	45	45	45

OFFICE ON WOMEN'S HEALTH

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$26,738,465	\$28,795,000	\$28,908,000	+\$113,000
FTE	50	52	52	—

Purpose and Method of Operations

The Office on Women's Health (OWH) was established in 1991 to improve the health of American women by advancing and coordinating a comprehensive women's health agenda throughout HHS. OWH is the government's champion and focal point for women's health activities in the Department. This structure is consistent with the overarching central direction of the Department's Strategic Plan to function as a single entity – "One HHS."

OWH works to promote women's health through research, health care services, and health education. Its mission is to improve the health and well-being of women across the lifespan by coordinating women's health programs, promoting health education and disease prevention, leading efforts and fostering partnerships to eliminate health disparities. OWH also:

- Advises the Secretary and the Assistant Secretary for Health on the scientific, medical, ethical and policy issues related to the advancement of women's health in the United States and internationally;
- Supports a Regional Women's Health Coordinator in each of the ten HHS Regional Offices; and
- Creates educational campaigns and communication efforts to bring women in every region of America reliable information on a myriad of health topics.

OWH's outreach activities and programs include the National Women's Health Information Center (www.4woman.gov or 1-888/994 WOMAN, TDD: 1-888-220-5446). In addition, the *Pick Your Path to Health Campaign* is the Government's only comprehensive health education campaign for women of color. In FY 2003, OWH will broaden the concepts of targeting the underserved by extending the campaign to include rural women and women with disabilities.

OWH also continues to be responsive to the President's priority health issues, such as health care and the uninsured. The National Centers of Excellence (CoE) in Women's Health, which are innovative, comprehensive and integrated national model programs in women's health, were established by OWH in October 1996 and have focused on efforts to provide health care to the underinsured or uninsured. OWH works through "armies of compassion" to extend the effectiveness and reach of women's health activities by establishing integrative approaches that

foster partnerships and allow sharing of resources, expertise and energy with public and private organizations.

"Closing the Gaps in Health Care" is Goal 3 of the HHS Strategic Plan. This goal can be achieved by expanding the availability of health services for populations with special needs, including persons with HIV/AIDS. OWH's Women and HIV/AIDS Program has funded small women's service organizations and community-based organizations (CBOs) to enhance their capacity to deliver HIV prevention and support care services to minority women.

"Health care safety net" activities are a component of the National Community Centers of Excellence (CCOE) in Women's Health program, whose primary mission is to integrate, coordinate and strengthen linkages between activities that are currently implemented in the community to reduce fragmentation in women's health services, and to foster "best practices" that coordinate and integrate women's health activities at the community level.

OWH actual and planned accomplishments are consistent with the goals of the HHS Strategic Plan and the OPHS GPRA Measures.

Strengthening Prevention

OWH is developing a *Healthy Lifestyle Toolkit for Girls and their Families* called BODYWORKS. The purpose of this kit is to provide materials, information, and suggested activities to encourage healthy eating and physical activity for girls and their families. The long term goal is to foster healthy lifestyle habits that young women will maintain the rest of their lives to decrease the risk of obesity and its consequences. In addition, OWH is developing an awareness campaign for girls about dietary supplements and the impact the media has on young women's attitudes and behavior concerning the use of dietary supplements.

OWH is developing web presentation and school curriculum materials on *Negotiating Skills for Girls* that focus on teaching girls about healthy relationships, street safety, and internet safety. The materials will also provide girls with tools to resist risky and unhealthy behaviors when they are in situations where peers may be engaging in such activities.

In FY 2002, OWH funded violence against women programs that strengthened the prevention of violence against women. For example, the National Black Women's Health Project in Washington DC, a national, non-profit organization that targets African-American Women of all ages to increase health awareness, was funded to develop and implement an HIV/AIDS/STDs and violence prevention education program for young minority women ages 18-25. The Women's Center in Jacksonville, FL, a community-based nonprofit women's center, was funded to provide individual and group counseling to women who are adult victims of childhood sexual violence as part of a program that provides psycho-social assessments, individual counseling, education groups, and appropriate referrals to community services.

In FY 2002, OWH implemented two violence against women interagency agreements. One agreement in Partnership with the Administration on Aging (AoA), to formulate a culturally competent educational program for domestic violence in *Later Life* as developed by the National Clearinghouse on Abuse in Later Life, a project of the Wisconsin Coalition Against Domestic Violence and distributed by the AARP. The Partnership with the Administration for Children and Families (ACF), Office of Community Services, provided an assessment of the prevalence of intimate partner violence among persons with disabilities in minority and under-served communities.

OWH partnered with several OPDIVs and national and community organizations to convene the "National Young Women's Health Summit 2002: Parents as Partners" on July 31-August 4 in Washington DC. More than 390 people participated, including young women ages 12-17, mentors, and parents. The goals of the Summit were to bring together both young girls and adults to discuss the issues facing young girls/women, promote positive images of young women in the media and community, promote the development of leadership skills through the formation of mentoring relationships between young and older women, and establish a network for interaction, information, and community action for young girls and women. Health information promoting healthy lifestyles was disseminated and discussed at the Summit.

In FY 2002, OWH increased funding for its seven HIV/AIDS community-based and/or women-based organizations in rural and urban communities across the nation to address gaps in the care and service of women living with HIV/AIDS. Two programs addressed "Incarcerated and Newly Released Women with HIV/AIDS/STDs." Four programs focused on "Model Mentorship" partnerships in which two minority health organizations provided technical assistance to two small community-based organizations in order to increase their capacity for effective HIV prevention service delivery. One program piloted the development of "HIV Prevention Education with At-Risk Women in the Rural South."

Consistent with Goal 1 of the HHS Strategic Plan to "Reduce the major threats to the health and well-being of Americans," Region I has supported educational activities on cardiovascular disease (CVD) in Women through work and funding for the Maine "Women and CVD Plan and Report (2001)" and the Vermont "Women and Heart Disease: Working Toward Prevention Conference (2002)" which promoted awareness and prevention strategies. The Region I Women's Health Working Group held quarterly meetings which focused on obesity and tobacco use among women. In addition, Region VIII is working on a year-long collaboration with the State of Colorado focused on creative community approaches to reducing tobacco use among women.

All of the Regional Women's Health Coordinators (RWHC) have developed projects for access to health care for incarcerated women. These projects provide public health information to inmates and their families during incarceration and after release. Several of the RWHCs have made presentations on these efforts to interested groups, including workgroups in the criminal justice system.

In FY 2002, OWH was chosen for sponsorship by the Ad Council for a three-year public service National Breastfeeding Awareness Campaign, which will result in 40 million dollars of free advertising on television, radio, newspapers, and magazines to increase US breastfeeding rates.

In FY 2003, OWH will continue its leadership role in planning and promoting National Women's Health Week in May 2003 and is planning *National Women's Check-up Day* during that week. In FY 2002, OWH provided leadership for collaborative efforts related to promoting National Women's Health Week. More than 100 governors, mayors, and tribal leaders issued proclamations, several radio stations hosted call-in shows, and events were held around the country.

OWH National Women's Health Information Center's (NWHIC) web site, www.4woman.gov, had five million user sessions from December 2001-December 2002. An average of 385,000 users per month visit the web site, with an average of 13,705 user sessions per day during the twelve-month period. The site has received several prestigious national awards. In addition, from December 2001-December 2002, there were 44,995 phone calls to NWHIC, an average of 3,750 per month. In FY 2002, 150,000 Women's Health Daybooks were printed and disseminated. Various women's health magazines and newspapers have consistently promoted the National Women's Health Information Center in articles.

An OWH web site, www.4girls.gov, provides girls ages 10-16 with information on fitness, nutrition, stress management, relationship with friends and family, peer pressure, suicide, drugs, self-esteem, and other topics in an interactive, user-friendly format. Although the site is only four months old, it is averaging a half a million hits per month and numbers are steadily increasing.

In FY 2002, OWH sponsored a one-day Women's Institute on historical implications and emerging issues relative to women and HIV/AIDS during the US Conference on AIDS, September 19-22, 2002.

OWH's National Bone Health Campaign (NBHC) is a multi-year national campaign to promote optimal bone health in girls 9-12 years old, and thus reduce their risk of osteoporosis later in life. The goal is to educate and encourage girls to establish lifelong healthy habits, especially increased calcium consumption and physical activity to build and maintain strong bones. In addition to girls 9-12 years old, the campaign will target adults who influence them, including parents, teachers, coaches and youth group leaders and health care professionals. To help extend the reach and impact of its messages, the NBHC has created a national partnership network of Federal, State and local government allies, and non-profit organizations. To date, there have been more than 600,000 hits on its award winning web site, more than a million materials have been distributed across the nation, and there have been over 20 million references to the campaign in the media.

In March 2002, in partnership with the HHS Coordinating Committee on Women's Health and

14 non-profit organizations, OWH presented a National Town Hall on Menopause to highlight the latest developments in this area. Video copies of the Town Hall have been distributed to the Regional Women's Health Coordinators.

Closing the Health Gaps

Because the deaf community has special barriers to health information, hearing impaired youth frequently grow up with less information about their own health status and needs than those who hear. OWH is assessing how and what kind of health information deaf girls need and what format they would like this information.

"Improving the economic and social well-being of individuals, families, and communities, especially those most in need," is a critical goal of the Department's Strategic Plan. OWH Region VIII actively sought contracts with several tribal health organizations and is currently funding a conference on sexual assault and domestic violence prevention in Indian country, a breastfeeding education project on a reservation, and a health screening project for urban American Indian women. In FY 2001, Region VII developed a regional domestic violence resource card for survivors, educators, service providers and advocates of domestic violence. This card provides a safety plan, common complaints of victims, a list of items to take when she decides to leave her perpetrator and recommended questions for the nurse or doctor. Region VII partnered to host a domestic violence forum on October 16, 2002 in Kansas City, MO, to address barriers.

In FY 2002, OWH partnered with the Association of Black Cardiologists to support pilot heart disease prevention projects for women in six African American churches across the United States.

OWH has successfully expanded the Pick Your Path to Health Campaign for FY 2002. Proposals were solicited from organizations across the nation to implement community-based programs that motivate, educate, and empower women to take small steps to improve their health and quality of life. Awards were made to 13 organizations in September 2002, in various cities across the country. Targeted audiences include African Americans, Latinas, Asian Americans, Native Americans, incarcerated women, rural women and homeless women. Two additional pocket planners will be produced during FY 2003 to reach women living in rural areas and women with disabilities.

In FY 2002, OWH provided conference support funds to various organizations and associations to increase the awareness of health issues regarding women of color, women in rural communities, and disadvantaged women. OWH also provided support and participated in the planning and coordination of the National Hispanic Health Leadership Summit, August 15-17, 2002, in San Antonio, Texas. This was a working and planning summit to provide policy recommendations to improve the health of the diverse Hispanic communities in the United States.

OWH's Minority Women's Health Panel of Experts completed its selection of new members. Thirty members represent all five racial/ethnic groups (African American, Asian American and Pacific Islander, Native Hawaiian, Native American, and Hispanic). This panel continues to assist OWH in promoting health education and eliminating health disparities.

In FY 2002, OWH and Spelman College, an historically black college in Atlanta, GA, initiated the Spelman College Health and Wellness Initiative, which aims to increase awareness of African American women's health issues for the student body and increase physical fitness, nutrition, and the spiritual health of the student. An intervention study will provide recommendations for further utilization and study.

Strengthening the Public Health Infrastructure

In a recently completed comprehensive two-year qualitative and quantitative evaluations of OWH Centers of Excellence (CoE) program, the national designation was found to have a significant impact on widening the scope of women's health within the institution and in developing and reinforcing multidisciplinary practices across the CoE components. CoE patients were more satisfied with their care and received significantly more screening tests and counseling services than women in national and local benchmark comparisons. In FY 2003, these data will be compared to similar surveys already conducted by the Veterans' Administration Women's Health Centers.

To further expand the Community Centers of Excellence in Women's Health (CCOE) program, five new CCOE awards were made in September 2002. In FY 2000, OWH funded three new CCOE's – one rural and two urban centers. In an effort to increase the geographic distribution of the CCOE model, OWH awarded four new CCOEs in FY 2001 – two rural and two urban. One center targets predominantly Asian American and Pacific Islanders, one serves a large elderly population, and two are located in a region that did not have a National Centers of Excellence in Women's Health (CoE) program.

Since 1996, the CoEs have been working to provide an integrated system of women's health care (one-stop shopping) for women throughout the academic healthcare system. In 2000, the CCOEs joined the CoEs in providing the same integrated system of women's health care at the community level. The CCOEs and CoEs are currently developing joint community outreach projects covering four topic areas: domestic violence, healthy girls/healthy relationships, heart disease and menopause based upon unmet needs in their respective service catchment areas. Future joint projects will target such areas as diabetes, obesity, HIV/AIDS, and women's cancers.

In addition, OWH is currently conducting an evaluation of these joint projects in an effort to objectively document the process and outcome of the two programs working together to provide integrated health services to women in their respective targeted communities.

OWH provided 2002 violence against women funds to the University of Maine, School of Social

Work, to develop a curriculum module for schools focusing on the abuse of women with disabilities. The goal of this curriculum is to cut across social work content areas (human behavior and the social environment, direct practice, macro-practice, research, and field). Deliverables would include a written component and a CD Rom for instructors to use to integrate material into the classroom.

Finally, OWH served as the coordinating agency for the HHS Women's Health Time Capsule Initiative. Working with other Departmental agencies to ensure the Department spoke with one voice, a "significant accomplishments in women's health during the past century" document was prepared. In addition, items that made a difference in women's health were enclosed in a time capsule and placed on the campus of the National Institutes of Health (NIH). The time capsule was registered with the International Time Capsule Society and archived at the NIH. It is scheduled to be opened in the year 2100.

Rationale for the Budget Request

The FY 2004 request for OWH is \$28,908,000, a net increase of \$113,000 above the FY 2003 President's Budget. This level includes a cost savings from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies.

Transformation of the Centers for Excellence. By redirecting funds, OWH will provide \$2,860,000 to support a Centers of Excellence Transformation. The funds will be principally used to expand the Centers of Excellence program to include a specific focus in rural areas and other geographic areas where the current Centers do not have sufficient reach, and/or to establish new Centers where indicated, to address a range of prevention issues. Some of the funds may be used to transform existing centers into goal-driven, prevention-oriented programs.

OFFICE ON WOMEN'S HEALTH

Program Data

Activity	FY 2002 Actual	FY 2003 Pres Budget	FY 2004 Estimate	Change +/- 03
Centers of Excellence Transformation	—	—	\$2,860,000	+\$2,860,000
National Centers of Excellence ...	\$790,000	\$1,950,000	1,950,000	—
National Community Centers of Excellence	1,720,000	2,250,000	2,250,000	—
CoE/CCoEs Joint Projects	990,000	100,000	100,000	—
Evaluation of Newly Awarded CoE's	310,000	400,000	400,000	—
Eating Disorders	206,000	425,000	425,000	—
Breastfeeding Initiative	1,154,000	1,540,000	—	-1,540,000
Adelphi Breast Cancer (earmark) ..	50,000	—	—	—
4Girl Power! Campaign Expansion	130,000	—	—	—
Homeless Veteran Women	—	175,000	175,000	—
Lesbian Health	30,000	40,000	—	-40,000
National Women's Cardiovascular Disease Prevention Campaign ..	446,000	1,380,000	1,380,000	—
State Data on Gender and Race/ Ethnicity	1,617,000	680,000	—	-680,000
National Leadership Mentoring Program	30,000	—	—	—
Osteoporosis	1,671,000	1,700,000	1,700,000	—
Women's Cancers Initiative	200,000	250,000	250,000	—
Depression and Mental Health	400,000	500,000	500,000	—
Female Adolescent Regional and State Capacity Building	140,000	—	—	—
HIV/AIDS in Minority Communities	795,000	1,040,000	1,040,000	—

General Departmental Management

Activity	FY 2002 Actual	FY 2003 Pres Budget	FY 2004 Estimate	Change +/- 03
Lupus Education Campaign	615,000	600,000	—	-600,000
Minority Women's Health	60,000	175,000	175,000	—
Secretary's Organ and Tissue Donation Initiative	100,000	—	—	—
Violence Against Women	594,000	525,000	525,000	—
Young Women's Health Summit ..	326,000	70,000	70,000	—
NWHIC Daybooks	800,000	500,000	500,000	—
Pick Your Path to Health	396,000	470,000	470,000	—
National Women's Health Information Center	2,875,000	3,010,000	3,010,000	—
Exhibits	14,000	—	—	—
General Contract Use	996,000	483,000	483,000	—
Co-sponsorships (includes IAA and others)	900,000	900,000	900,000	—
Operating Expenses	8,383,000	9,632,000	9,745,000	+113,000
TOTAL, Budget Authority	\$26,738,465	\$28,795,000	\$28,908,000	+\$113,000

OFFICE ON WOMEN'S HEALTH

Workload Data

ACTIVITY	FY 2003	FY 2004
CONTRACTS		
National Centers of Excellence	13 Continuing 3 New	16 Continuing 3+ New
Community Centers of Excellence	3-4 New 12 Continuing	15-16 Continuing
National Women's Health Information Center	Estimate up to 50,000 calls, 6 million visitors and 100 million hits	Estimate up to 75,000 calls, 7.2 million visitors and 150 million hits
Centers of Leadership in Academic Medicine	3	0
HIV Contracts	10-12	14-16
Violence Against Women	16	18
Lupus	18	0
Mental Health	1	1
Breastfeeding	15	0
Heart Disease	5	5
State Data Contracts/Agreements on Gender Race Ethnicity	2	0
Organ and Tissue Donation	2	2
CONFERENCES & MEETINGS		
National Conferences (Exhibitors, Speakers) - Minority - Organ and Tissue Donation	7-9 6	7-9 6
Regional Conferences (Exhibitors, Speakers)	19	26

General Departmental Management

ACTIVITY	FY 2003	FY 2004
Co-sponsorship of Conferences with Federal Agencies and Non-Federal Organizations		
- Mental Health	1	1
- Minority Health	7-9	7-9
- COE Forum	1	1
- Lupus	4	6
- VAW	4	6
- Other	30-40	30-40
Committees/ Panels/ Work Groups/ Partners		
- Lupus	4	0
- PYPH Media Advisory Panel	1	1
- VAW Youth/Elderly/Disabled/Batterers	6	6
- Women's Health Week	1	1
- Minority Women's Health Panel of Experts	1	1
PUBLICATIONS (estimated to reach 40 million people)		
Fact Sheets on Women's Health	18	18
Scientific Articles (misc.)	20	20
- COE	4	4
Mental Health (publishing reports)	50,000 copies	50,000 copies
Monographs	8	8
INVENTORIES/ DATA BOOKS		
*WH and the Environment		
- Web Distribution	1,200	1,200
* Regional/ State WH Data		
- Web Distribution	1,500	1,500
* Dictionary/ Journal Lists		
- Web Distribution	150,000	150,000

General Departmental Management

ACTIVITY	FY 2003	FY 2004
EDUCATIONAL BOOKS/ MATERIALS		
- Violence Against Women booklet	50,000	75,000
- WH Daybook	200,000	300,000
- PYPTH Pocket Planner	100,000	100,000
- PYPTH Native American Pocket Planner	25,000	25,000
- NWHIC FAQs		
Hardcopy distribution	15,000	15,000
Website distribution	180,000	180,000
- OWH Fact Sheets		
Hardcopy distribution	18,000	18,000
Website distribution	50,000	50,000
- Breastfeeding (4 booklets for general market, African Americans, Native Americans, Hispanic markets)		
Hardcopy distribution	75,000	75,000
Website distribution	20,000 hits/month	20,000 hits/month
PSA's	4 television	4 television
	4 radio	4 radio
	2 general market	2 general market
Ads	1	1
Campaign Launch	100	100
Billboard Ads	10 new	6 new
- CoE pamphlets	2 new 2 updates	
Newsletters		
- COE (issues)	2	2
Hardcopy distribution	1,200 each = 2,400	1,200 each = 2,400
Website distribution	15,000	15,000
- NWHIC List Service Distribution	12 copies x 2000 each = 24,000	12 copies x 3000 each = 36,000
- PYPTH List Service Distribution	52 copies x 900 each = 46,800	52 copies x 1200 each = 62,400

ACTIVITY	FY 2003	FY 2004
EDUCATIONAL CAMPAIGNS		
- Bone Health	260,000 (materials, etc.)	260,000 (materials, etc.)
- Girl Power! Educational Materials		300,000 assignment books, 10 million promotional materials
Web Site Traffic		2.5 million hits/month
- Eating Disorders Website distribution	20,000 hits/month	30,000 hits/month
Packets (Obesity/Bodywise)	100,000	150,000
- 4Girls Web Site	2 million hits/year	3 million hits/year
Includes chronic illness site	100,000 visitors/year	200,000 visitors/year
- NWHIC Distribution/User Sessions	100 million hits/year 6 million visitors/year	150 million hits/year 7.2 million visitors/year
Media Conference	1	1
- Minority Women Panel of Experts Brochure	1,000	1,000

OFFICE FOR HUMAN RESEARCH PROTECTIONS

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$7,015,000	\$7,554,000	\$7,587,000	+\$33,000
FTE	35	39	39	—

Purpose and Method of Operations

The Office for Human Research Protections (OHRP) was created in June 2000. Together with colleagues from within the Department and throughout the Federal government, OHRP has pioneered a new approach to the protection of human subjects in research, one based upon the concept of shared goals and responsibilities – recognizing that the first responsibility of everyone involved in the human research process must be to protect the rights, interests and well-being of those individuals who voluntarily participate in our research activities.

This new system is not simply an improvement of the existing oversight and sanction approach, but a system focused on prevention. Toward this end, every party to research must be properly trained and educated to accept and fulfill their responsibilities for protecting research subjects as a necessary condition of participation. The general public must also be better informed about the nature of the research process and what participation entails.

OHRP is implementing its strategic vision for applying the principles of continuous quality improvement, well developed in the private sector, to the human research oversight process. Through a comprehensive program of education, support, quality improvement initiatives, proactive compliance oversight and improved policies, OHRP will continue to enhance the performance, effectiveness and efficiency of the human research process. Its efforts are complemented by the development of voluntary programs of accreditation of human research protection programs, a process developed by the private sector with the support and encouragement of the Department.

With the leadership of OHRP, the Department has made significant progress in a global effort to improve the system for protection of human research subjects. Specifically, OHRP has accomplished the following tasks furthering the mission of HHS.

Division of Education and Development (DED)

Universally, education is recognized as one of the most important elements in improving protections for human research subjects. In FY 2002, DED conducted 85 presentations on human protections topics, six National Workshops (partnering with FDA/VA/NIH/NSF), and

four Town Meetings (three via video-conferencing, two domestic and one international). OHRP expanded its outreach efforts by designing a new exhibit booth and staffed it at four professional meetings as well as at all OHRP National Workshops. DED also conducted Human Research Protections Workshops at two professional meetings, set up an e-mail Q&A mailbox and answered approximately 1200 inquiries from the research community. OHRP began coordinating the revision of the Institutional Review Board (IRB) Guidebook, originally published in 1993.

In FY 2003, OHRP plans to: increase the number of presentations to more than 100; increase the number of Workshops to seven and the number of Town Meetings to six; increase the number of professional meetings at which we have exhibit booths to six; increase the number of workshops at professional meetings. OHRP will use video-conferencing technology as a cost effective means of achieving these goals. OHRP will near completion of an initial draft of the revised IRB Guidebook, complete and make available an Education Clearinghouse Website and revise our email and phone Q&A process to achieve greater efficiency and effectiveness in educating the research community about the rules and regulations governing the protection of human research subjects.

In FY 2004 OHRP plans to continue increasing educational outreach by increasing the number of presentations, workshops, and town meetings.

Division of Compliance Oversight (DCO)

At the time of its creation, OHRP inherited an enormous backlog of unresolved compliance oversight cases that had to be completed before new initiatives could be launched. At its peak, the number of open investigations exceeded 180.

In FY 2002, DCO opened 38 new compliance oversight investigations and closed 101 compliance oversight investigations. This reduced volume of open compliance oversight investigations from 117 to 54. During this period, DCO also issued 154 compliance oversight determination letters and conducted compliance oversight site visits at four institutions, two for-cause and two not-for-cause. DCO also began to expand not-for-cause compliance oversight evaluations by conducting two additional evaluations initiated via correspondence. This shift toward not-for cause evaluations emphasizes the initial steps in an evolution from a reactive compliance-focused system to a proactive performance-based system focused on prevention of harm to research subjects. This program provides an important complement to the new performance-based quality improvement programs described below.

In FY 2003, DCO has opened five new compliance oversight investigations and closed 14 compliance oversight investigations. OHRP anticipates opening a total of 35-40 new investigations and reducing volume of open compliance oversight evaluations to 25-30 in FY 2003. The DCO anticipates conducting three for-cause compliance oversight site visits and expand not-for-cause compliance oversight surveillance program with up to 20 evaluations, and

four not-for-cause compliance oversight site visits.

In FY 2004, DCO will build on their accomplishments in FY 2003 by opening 35-40 new compliance oversight investigations and reducing the volume of open compliance oversight evaluations to 20. The DCO anticipates conducting two for-cause compliance oversight site visits, and expanding not-for-cause compliance oversight surveillance program with up to 30 evaluations, and six not-for-cause compliance oversight site visits.

Division of Assurances and Quality Improvement (DAQI)

The introduction in 2001 of a simplified and streamlined Federal-Wide Assurance (FWA) process that provides greater flexibility and accountability in the oversight process marked a direct response to the recommendations of the Office of Inspector General for improvement of the human subjects protection process.

In FY 2002, DAQI approved 2,076 Assurances of Compliance (181 Single Project Assurances (SPAs) and 1,895 FWAs); processed approximately 950 registrations of IRBs; prepared and released a revised version of the FWA on March 20, 2002. DAQI also started development of a process for electronic submission of the FWA. DAQI completed the initial pilot testing of the OHRP Quality Improvement Program (QIP), including a Self-Assessment Tool for research institutions; implemented Stage 1 of the OHRP QIP, conducting a total of 19 QIP on-site consultations; conducted on-site consultations with six institutions in South Africa; and began development of Stage 2 (Quality Improvement) of the OHRP QIP. The new program, will utilize a case-based reference model to allow institutions to compare their performance with comparable programs.

Accomplishments for FY 2003 will include: approve approximately 2,000 Federal-wide Assurances and process approximately 800 IRB Registrations. The DAQI has released electronic submission of the FWA in December 2002 and will work to release electronic submission of IRB Registration, as well as the ability to update FWAs and IRB Registrations via the internet. The DAQI will strive to complete at least 80 QIP consultations with research institutions and/or independent IRBs. The DAQI will develop Stage 2 of the QIP which will provide OHRP with performance-based measures on an IRB's ability to review human subjects research. OHRP will initiate several expert panels to conduct peer review of research protocols. These reviews will be consolidated into a library used to establish a standard reference from which IRBs can measure and compare their own performance.

Projections for FY 2004 include approving approximately 2,000 FWAs and processing approximately 600 IRB Registrations. The DAQI will strive to complete at least 200 QIP consultations with research institutions and/or independent IRBs. Additionally, DAQI will work to expand the library of research protocols reviewed by expert panels for Stage 2 of the QIP.

Division of Policy Planning and Special Projects (DPPSP)

The DPPSP was formally created on March 6, 2002. Since that time, the DPPSP has developed and issued guidance documents, or, published Federal Register notices soliciting comments, on the following topics: research involving human embryonic stem cells; institutional review board procedures; continuing review; an OHRP proposal recommending HHS support of a research protocol entitled "Precursors to Diabetes in Japanese American Youth;" a proposed waiver of applicability of HHS regulations for the protection of human subjects for research relating to HHS epidemiologic research involving prisoners; and, with the Food and Drug Administration, a notice soliciting public review and comment on a proposed research protocol entitled "A Multi-center, Randomized Dose Response Study of the Safety, Clinical and Immune Responses of Dryvax Administered to Children 2 to 5 Years of Age."

DPPSP also worked with the Secretary's Privacy Council and the Office for Civil Rights to revise the research provisions of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. The final Privacy Rule was published in the Federal Register on August 14, 2002.

In addition to the guidance documents developed and issued by DPPSP, staff have: presented over two dozen talks on the impact of the HIPAA Privacy Rule on human subjects research to members of the research community; presented over a half dozen talks on the Department's Interim Guidance on Financial Relationships and Human Subject Protections; and presented several talks on the Department's Regulations on Research Involving Pregnant Women, Fetuses and Neonates (45 CFR, Part 46, Subpart B) adopted in December 2001. DPPSP was also responsible for responding to more than 180 media queries related to clarifying and supporting OHRP activities

In FY 2003, DPPSP plans to develop policy and guidance documents on: Third Parties in Research; Engagement of Institutions in Research; HIPAA Privacy Rule and Research; Informed Consent and Non-English Speakers; and Subpart B Regulations on Pregnant Women, Fetuses and Neonates. DPPSP will develop and issue a Notice of Proposed Rule Making (NPRM) on IRB Registrations and an NPRM proposing human subjects protection training and education requirements; and, issue jointly with FDA, an Advanced Notice of Proposed Rule Making (ANPRM) to solicit comments on proposed standards for the participation of persons with decisional impairment who participate in research.

In FY 2004, DPPSP plans to develop and update up to ten policy and guidance documents regarding regulatory requirements, and ethical issues for biomedical and behavioral research involving human subjects as well as organizing and coordinating up to ten consultations with panels of experts for research involving prisoners and children; and, research involving pregnant women, fetuses and neonates.

In addition to Divisional activities, OHRP will continue to exercise international leadership

promoting protection of human research subjects around the world. Specific international accomplishments during 2002 include: initiating development of Departmental guidance explaining criteria for implementation of the rulings of "at least equivalent protections" provisions of 45 CFR.101(h); participating in ten international meetings across 5 countries (South Africa, China, Thailand, Kazakhstan and Uruguay) representing Departmental policies to promote a culture of human research subject protection; partnering with the World Health Organization (WHO) to provide technical and fiscal support for four international workshops in Asia, Latin America, Russia, and Africa, to bolster the human and institutional capacity for ethical review in and for developing countries. This program will continue in FY 2003 in, Brazil, Canada, and Ethiopia; identifying education/training materials for translation into other languages (Spanish, French, Russian, Chinese) in order to facilitate access to OHRP documents by non-English speaking users of the OHRP website.

Expected FY 2003 and FY 2004 outputs included: completing an analysis the human research protections policies and procedures for Australia for use in institutional assurances required by 45 CFR 46; completion of Departmental guidance explaining criteria for implementation of the rulings of "at least equivalent protections" provision of 45 CFR.101(h); participating in seven to twelve international meetings represent US to promote a culture of protection of human research subjects; expand technical and fiscal support for seven international workshops to enhancing capacity for ethical review in and for developing or resources poor countries; assist with additional Quality Improvement consultations; supporting international accreditation of human subject protections programs.

Rationale for the Budget Request

The FY 2004 request for OHRP is \$7,587,000, a net increase of \$33,000 above the FY 2003 President's Budget. Of this increase, \$28,000 will expand OHRP's outreach efforts through further development of its Public Education Campaign. This level includes cost savings from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies.

Public Education Campaign. OHRP currently engages in a variety of activities to educate constituents concerned about the ethical conduct of human-subject research, which includes institutions that engage in human-subjects research, institutional review boards, researchers, and research participants. In FY 2004 OHRP is requesting \$28,000 to take these initiatives to the next logical step: the development of a wide-reaching Public Education Campaign (PEP). The PEP would help improve health outcomes as members of the research community and the general public become more educated about biomedical and behavioral research and the role of human-subject ethics in that research.

In FY 2003, OHRP intends to initiate the first phase of the PEP by conducting needs assessment and audience-profiling. This will provide baseline information about the impact of current outreach activities and the characteristics of our current primary target audience, professionals

working directly in human research protections. Phase one will include information gathering, analysis and evaluation of current OHRP outreach activities such as: website usage statistics (WebTrends) for a minimum of six months; follow-up impact questionnaires to OHRP workshop participants to stratified random sample of 2002 participants; track topics, source and length of incoming telephone calls and e-mails across all divisions, by topic and frequency. Additionally, OHRP will use geo-mapping technology to identify location of : NIH grants, compliance cases, education workshops, OHRP exhibit displays, professional staff travel, phone and e-mail queries, and all site visits, except for-cause compliance.

From these analyses, OHRP will identify the most successful message components, the most highly utilized outreach methods for the primary target audience and those parts of the country in greatest need of outreach services, the second phase, strengthening existing outreach, will build on this data and begin in FY 2004.

TRANSFORMATION OF THE COMMISSIONED CORPS

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$—	\$—	\$5,000,000	+\$5,000,000
FTE	—	—	—	—

Purpose and Method of Operations

The US Public Health Service Commissioned Corps began in 1871 as a means of bringing a unified command and high professional health standards to the independent facilities of the Marine Hospital Service. Using the career military model, the first Surgeon General – Dr. John Woodworth – instituted the Commissioned Corps through administrative regulations, which were given statutory basis in 1889. Initially limited to physicians, the Commissioned Corps gradually developed to include nearly all of the health professions.

The Corps' military construct allowed its members to be assigned wherever needed (e.g., in underserved areas; with State and local public health officials and school districts; to deal with epidemics and other emergent situations). It was so successful at its tasks that pieces of it were broken off to establish other agencies: the Centers for Disease Control and Prevention, the National Institutes of Health, the National Institute of Occupational Health and Safety, and virtually every health agency in the Department. When each such agency was broken off, Corps members went with it – with responsibility for hiring and direction also given to the agency, rather than retained within a unified Corps structure. Daily direction and supervision of Corps officers is now scattered across the agencies; therefore, there is no longer a unified cadre of health care providers whose focus is on responding to public health needs, and who can be directed to serve where needed – specifically, in areas where primary healthcare and critical public health services are inadequate.

In an effort to enhance the ability of the Nation's health care system to effectively respond to public health challenges, including terrorism in all its forms, HHS proposes to transform and modernize the Commissioned Corps. The plan revolves around two core concepts: to establish an integrated command and control structure capable of responding to emergencies while simultaneously strengthening the nation's public health infrastructure; and to develop a health force that is rapidly deployable and adaptable, and which can integrate resources from State, local and non-government partners into a unified response system. The goal is to make the Commissioned Corps a health force capable of implementing the public health directives of the President and the Secretary.

Rationale for the Budget Request

The FY 2004 request for the Transformation of the Corps is \$5,000,000, an increase of \$5,000,000 above the FY 2003 President's Budget.

COMMISSIONED CORPS READINESS FORCE

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$1,200,000	\$1,300,000	\$1,287,000	-\$13,000
FTE	5	6	6	—

Purpose and Method of Operations

The Commissioned Corps Readiness Force (CCRF) is a cadre of approximately 1,300 active duty US Public Health Service (PHS) officers, qualified by special training and skills, that are ready to deploy in an emergency situation under austere conditions. They can be mobilized rapidly in times of extraordinary need during disaster, strife, or other public health emergencies and in response to domestic or international requests to provide leadership and expertise by directing, enhancing, and supporting the missions of the PHS and other HHS agencies, other US government agencies, and/or other respondents.

CCRF officers can be deployed within hours, either as individuals or as purpose-specific strike teams. In the event of a national or international health emergency, the CCRF response can be "custom tailored" in that CCRF officers who have a wide variety of professional training and experience (e.g., clinical, regulatory, research) are selected and aggregated as needed. Officers are often utilized in the context of pre-positional assets for high-profile mass gatherings, such as meetings of the International Monetary Fund/World Bank, special population needs such as the mass immunization of school-aged children in Washington DC, or humanitarian assistance such as for the Kosovar Refugees.

CCRF was established in 1994 to improve HHS's ability to respond to public health emergencies. Corps officers who wish to be members of the elite CCRF must meet certain requirements, including physical fitness, height and weight standards, immunization, basic life support training, and completion of web-based courses related to emergency response and humanitarian assistance.

The CCRF was deployed to 14 separate activations in FY 2001, sending approximately 750 officers to events as varied as Tropical Storm Allison, the World Trade Center Collapse, six anthrax prophylaxis sites, missions involving a staged presence in case of a mass casualty episode at a special event, and public health shortages in the HHS Operating Divisions. In FY 2002, the CCRF deployed to the Winter Olympics, the State of the Union Address, an Avian Influenza outbreak in Virginia, Hurricane Lili, Typhoons Chata'an and Pongsona, assisted with vaccinating over 19,000 school children in Washington DC, and several special security events.

Rationale for the Budget Request

The FY 2004 request for CCRF is \$1,287,000, a net decrease of \$13,000 below the FY 2003 President's Budget. This level includes a cost savings from consolidating administrative function and implementation of effective workforce planning and human capital management strategies.

CCRF is a key component in transforming the Commissioned Corps into a cadre of rapidly deployable and adaptable health officers. The current number of officers on CCRF rosters is just over 1,300. However, given the broad variety of threats against this country, it is necessary to increase the Department's capability to respond. Therefore, the plan is to expand CCRF to 2,000 officers by the end of 2003 and to 3,000 officers by the end of 2004 – and to eventually include all Commissioned Corps officers. This will require additional management and officer training, as each officer is only as good as the training and readiness vested in that officer. Given the necessity of training officers to be effective in scenarios involving biological, chemical, radiological and tactical weapons, more training opportunities must be provided as Corps membership expands. Similarly, each response is dependent on the capability of the CCRF program staff to carry out their responsibilities properly and effectively.

OFFICE OF RESEARCH INTEGRITY ¹

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	[\$6,935,000]	[\$7,635,000]	[\$7,974,000]	[+\$339,000]
FTE	29	29	29	—

Purpose and Method of Operations

The overall mission of the Office of Research Integrity (ORI) is to promote integrity in the research programs of the Public Health Service, both intramural and extramural, including responding to allegations of research misconduct. To accomplish this mission, ORI engages in research, education, oversight of institutional and HHS investigations, collaboration with external partners, including scientific societies and associations, and research institutions, and other activities intended to promote integrity and reduce misconduct.

In 1999, HHS reorganized the research integrity functions of ORI to place greater emphasis on educational activities, research, evaluation, and prevention of misconduct. In response to these changes, ORI adopted an action plan to increase activities and resources in these areas. A key part of this plan was the establishment of a research program to study the factors influencing research integrity and an education program on the responsible conduct of research.

A major portion of ORI's budget and resources is relevant to the Department's interest in the prevention of disease and promotion of health. ORI's overall mission supports the integrity of PHS research and the public confidence in such research. Since clinical trials, human studies, animal studies, and basic research lead to new drugs, devices, and medical interventions, confidence in the science base which leads to such improvements in health is closely intertwined with the beneficial products of the research. ORI is also emphasizing prevention in its programs by developing educational resources to support best practices and by supporting extramural studies through its research program on the indicators of research integrity and the causes of misconduct. Only through the development of this science base can PHS identify effective and cost efficient means of promoting integrity and preventing misconduct. ORI's mission to identify and take action in response to research misconduct also provides primary and secondary prevention by removing from research those who commit misconduct and reinforcing the scientific norms of honest scientists who conduct research responsibly.

¹ ORI is funded by NIH dollars, which are reflected as non-add.

Examples of ORI's accomplishments over the last few years include the following:¹

- Reviewed 289 allegations of misconduct, opened 54 formal inquiries and investigations, and made 21 findings of research misconduct.
- Reviewed over 200 institutional policies and procedures for regulatory compliance and responded to over 20 incidents of possible retaliation against good faith whistleblowers or non-compliance with regulatory requirements.
- Effectively settled 21 cases of research misconduct with actions that protect the public health and reviewed 12 or more civil suits for possible ORI or HHS action.
- Sponsored 10 workshops and conferences with research institutions, scientific societies, and others on research misconduct, the responsible conduct of research, and the promotion of research integrity. Provided funds for development of 13 educational products in RCR.
- Provided exhibits or posters on research integrity at 7 scientific meetings.
- Funded 16 grants to support research on misconduct, education in research integrity, conflicts of interest, and institutional practices that affect the integrity of the research environment. Initiated or completed studies on the feasibility of using consortia to assist extramural institutions with misconduct investigations; an Institute of Medicine report on "Integrity in Scientific Research: Creating an Environment that Promotes Responsible Conduct"; a survey on the incidence of research misconduct; "Analysis of Guidelines for the Conduct of Research Adopted by Medical Schools or Their Components"; and "ORI Education Program: A Needs Assessment."
- Provided on-site or telephonic technical assistance to 16 or more research institutions in handling allegations of misconduct.
- In compliance with statutory policy requirements, revised PHS misconduct regulations to adopt new OSTP definition of research misconduct and make other changes and prepared a draft revision of the PHS policy on education in the responsible conduct of research.

Planned accomplishments in the next few years are:

- Continue implementation of policy and regulatory changes to scientific misconduct and research integrity procedures adopted by the Department in response to government-wide policies initiated by the Office of Science and Technology Policy and internal reviews.

¹ Through June 30, 2002. All ORI data for are reported on a calendar year basis.

- Evaluate and implement as appropriate recommendations from the Institute of Medicine report on "Integrity in Scientific Research: Creating an Environment that Promotes Responsible Conduct."
- Initiation of a new ORI program to provide national coordination of RCR education to stimulate a sharing of resources, reduce duplication of effort, and provide uniformity and consistency where appropriate and consistent with extramural goals.
- Continue to develop the partnership between ORI and extramural programs aimed at the promotion of research integrity and investigation of allegations of scientific misconduct by expanding the publication of resource materials, improving Internet availability of information, and co-sponsoring at least 8 conferences and workshops.
- Conduct studies and evaluation reviews of the following: a survey of 5,000 randomly chosen principal investigators to identify research integrity measures utilized in biomedical research laboratories and a survey of the incidence of scientific misconduct and questionable research practices.
- In collaboration with the National Institute of Neurological Disorders and Stroke and other NIH institutes, award at least 15 grants for research on the commission and prevention of scientific misconduct, promotion of research integrity, and the responsible conduct of research under ORI's research program on research integrity.
- Award at least 15 grants or contracts to support the development of curriculum materials for teaching the responsible conduct of research.
- Provide technical assistance to at least 20 institutions which conduct investigations into alleged misconduct and need assistance.
- Continue implementation of new regulations on research misconduct and protection of whistleblowers by developing new guidance documents, model policies, and sponsoring workshops/conferences. Provide additional materials on the ORI website to provide effective and efficient tools for institutions in adopting policies and procedures consistent with the new regulations and institutional best practices.
- Initiate development of ORI quality assurance program to assist institutions in managing allegations of misconduct, resolving whistleblower retaliation complaints, and providing quality RCR education to institutional researchers funded by PHS grants. This will include self assessment tools, ORI staff technical assistance, model policies and best practices, and workshops/conferences.
- Assess 300 potential allegations of misconduct.

- Open 50 or more inquiries and investigations into alleged misconduct for ORI oversight.
- Recommend to the ASH for final decision 20 or more findings of research misconduct involving PHS funding.
- Cause 10 or more articles that misrepresent research results to be corrected or retracted.
- Defend ORI authorities and actions in specific cases before the Departmental Appeals Board and in civil litigation.
- Review 100 or more institutional policies for compliance with program regulations and for best practices.
- Respond to several whistleblower complaints of retaliation and institutional compliance problems.

Rationale for the Budget Request

The FY 2004 request for ORI is \$7,974,000, an increase of \$339,000, above the FY 2003 President's Budget; of which \$150,000 in program increases. This level includes cost savings from consolidating administrative functions and implementation of effective workforce planning and human capital management strategies.

Research Program on Research Integrity. An increase of \$150,000 is requested to continue a research program to study issues on research integrity, scientific misconduct, and the responsible conduct of research, including conflicts of interest, the conduct of clinical trials, integrity in clinical research, prevention of misconduct, and the evaluation of education in research ethics and responsible research. This proposal directly supports Objective 4.5 (Strengthening the Mechanisms for Ensuring the Protection of Human Subjects and the Integrity of the Research Process) of the HHS Strategic Plan for FY 2003-2008, draft 7/29/02. In FY 2001, ORI awarded seven grants from 25 competing applications with total funding in the range of \$1,000,000 per year for a two year project period. This substantially exceeded the amount allotted to the program; ORI and NIH institutes contributed the additional funding. In FY 2002, 30 competing applications were received and ORI funded nine awards, with additional contributions from NIH institutes for proposals germane to their mission. In FY 2003, \$1,400,000 has been requested for new and competing awards, with up to eight awards anticipated. In FY 2004, ORI is anticipating up to nine awards with a total funding commitment of approximately \$3,000,000, including both new awards and continuations. Of this amount, ORI is requesting \$1,550,000 and the remainder is expected to come from NIH institutes picking up individual awards relevant to their research discipline and extra funds from ORI, if available.

OFFICE OF RESEARCH INTEGRITY

Program Data

ACTIVITY:	FY 2002 Estimate	FY 2003 Pres Budget	FY 2004 Estimate	Change
Oversight and Case Resolution	\$1,889,269	\$1,889,269	\$1,889,269	+\$0
Assurance and Compliance Program	885,045	885,045	885,045	0
Education and Integrity Program	2,128,026	2,528,026	2,678,026	+150,000
Management of Allegations of Research Misconduct	400,000	400,000	400,000	0
Support Costs	1,632,660	1,932,660	2,121,660	+189,000
Total	\$6,935,000	\$7,635,000	\$7,974,000	+\$339,000

OFFICE OF RESEARCH INTEGRITY

Workload Data

Calendar Year	Misconduct Cases	Whistleblower Compliance/ Cases	Policy Reviews	Judicial Litigation
2000	Queries 173	Opened 5	Opened 263	Opened 1
	Cases Opened 26	Closed 3	Closed 320	Closed 3
	Cases Closed 27	Current 3	Current 59	Current 6
	Assessment Underway 36	Assessment		
	Current Ongoing Cases 31	Opened 14 Closed 10 Current 6		
2001	Queries 196	Opened 5	Opened -- 81	Opened 6
	Cases Opened 35	Closed 5	Closed 102	Closed 5
	Cases Closed 25	Current 3	Current 38	Current 7
	Assessment Underway 3	Assessment--		
	Current Ongoing Cases 41	Open 7 Closed 8 Current 5		
2002 ¹	Queries 190	Opened 4	Opened -- 175	Opened 0
	Cases Opened 41	Closed 3	Closed 209	Closed 0
	Cases Closed 32	Current 4	Current 4	Current 7
	Assessment Underway 8	Assessment--		
	Current Ongoing Cases 50	Open 6 Closed 8 Current 3		

¹Figures reflect workload through December 31, 2002

RENT AND COMMON EXPENSES

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
<u>RENT:</u>				
GDM	\$3,695,000	\$4,857,000	\$5,967,000	+\$1,110,000
OGC	5,192,000	5,348,000	5,439,000	+91,000
OPHS	3,390,000	3,468,000	3,528,000	+60,000
IGA	608,000	650,000	650,000	-
DAB	170,000	175,000	175,000	-
OGHA	<u>33,000</u>	<u>33,000</u>	<u>34,000</u>	<u>+1,000</u>
Total	13,088,000	14,531,000	15,793,000	+1,262,000
<u>Delegated Authority:</u>				
GDM	4,708,000	4,806,000	3,179,000	-1,627,000
<u>Related Services:</u>				
GDM	2,583,000	2,158,000	3,619,000	+1,461,000
OGC	<u>585,000</u>	<u>1,475,000</u>	<u>1,497,000</u>	<u>+22,000</u>
Total	3,168,000	3,633,000	5,116,000	+1,483,000
<i>Subtotal, GDM only</i>	<i>10,986,000</i>	<i>11,821,000</i>	<i>12,765,000</i>	<i>+944,000</i>
<u>Common Expenses:</u>				
GDM	2,942,000	3,548,000	2,784,000	-764,000
OGC	478,000	1,207,000	1,224,000	+17,000
OPHS	<u>2,921,000</u>	<u>2,994,000</u>	<u>3,039,000</u>	<u>+45,000</u>
Total	6,341,000	7,749,000	7,047,000	-702,000
<u>Service and Supply Fund Payment:</u>				
GDM	4,058,000	5,000,000	5,031,000	+31,000
OGC	2,046,000	2,635,000	2,671,000	+36,000
OPHS	4,611,000	4,681,000	4,762,000	+81,000
IGA	90,000	105,000	105,000	-
OGHA	<u>169,000</u>	<u>170,000</u>	<u>176,000</u>	<u>+6,000</u>
Total	10,974,000	12,591,000	12,745,000	+154,000
<i>Subtotal, GDM only</i>	<i>7,000,000</i>	<i>8,548,000</i>	<i>7,815,000</i>	<i>-733,000</i>

General Departmental Management

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
<u>Totals:</u>				
GDM	\$17,986,000	\$20,369,000	\$20,580,000	+211,000
OGC	8,301,000	10,665,000	10,831,000	+166,000
OPHS	10,922,000	11,143,000	11,329,000	+186,000
IGA	725,000	755,000	755,000	-
DAB	170,000	175,000	175,000	-
OGHA	<u>202,000</u>	<u>203,000</u>	<u>210,000</u>	<u>+7,000</u>
Total	\$38,306,000	\$43,310,000	\$43,880,000	+\$570,000

Purpose and Method of Operations

Payments to cover RENT/Delegated Authority, Related Services, Common Expenses, and Service and Supply Fund Payments are made from centrally-managed accounts on behalf of all GDM accounts except the Office of the General Counsel (OGC), the Office of Public Health and Science (OPHS), the Office of Intergovernmental Affairs (for the ten Regional Directors offices only); Departmental Appeals Board (for the Nursing Home Oversight Improvement Program only); and the Office of Global Health Affairs. The costs for these accounts are included in their individual sections of the budget request.

RENT/Delegated Authority and Related Services

Rental (RENT) payments to the General Services Administration (GSA) include funds to cover the rental costs of office space, non-office space, and parking facilities in GSA-controlled buildings. Delegated Authority includes funds to cover the operation, maintenance and repair of buildings for which management authority has been delegated to HHS by GSA; this includes HHS headquarters, the Hubert H. Humphrey (HHH) building. (NOTE: Delegated Authority amounts are spread across object classes other than 23.1, Rental Payments to GSA, where all RENT amounts are shown.) Related Services include funds to cover all non-RENT operations, maintenance and repair activities in GSA-controlled buildings (e.g., housekeeping, guard services and other security, building renovations).

The Facilities Management Group (FMG), in the office of the Assistant Secretary for Administration and Management, administers both RENT/Delegated Authority and Related Services funds for all headquarters facilities occupied by the Office of the Secretary. FMG also monitors the amount and type of space occupied by each STAFFDIV, and coordinates efforts to achieve the most efficient use of space, while maintaining a quality work environment. Over the past several years, FMG has completed a number of HHH Building improvement projects aimed at enhancing the functionality and physical appearance of the building, such as refurbishing and upgrading the auditorium and conference rooms to multi-purpose meeting facilities, and modernizing the building's restrooms.

Common Expenses/SSF Payment

Common Expenses include funds to cover administrative items and activities which cut across and impact all STAFFDIVs under the GDM appropriation. The major costs in this area include telecommunications (e.g., FTS and commercial telephone expenses), postage, printing, Worker's Compensation, Unemployment Insurance, and records storage at the National Archives.

Payments to the Service and Supply Fund (SSF) are included in the overall Common Expenses category, but are broken out separately here for display purposes. These payments cover the usage of goods and services provided through the SSF, including personnel and payroll services, finance and accounting activities, and reprographics and electronic communication services (e.g., voice-mail and data networking).

Rationale for the Budget Request

The Department has long stressed the importance of providing a quality work environment for HHS employees that is safe, clean, healthy and meets their job-related needs. As in past years, OS continues to complete numerous building improvement projects aimed at enhancing the security, functionality and physical appearance of the HHH Building.

The FY 2004 Rent/Delegated Authority request reflects a net increase of \$944,000 over the FY 2003 President's Budget. This increase is a direct result of the RENT increase projected by GSA for the particular HHS properties involved, plus increases in Related Services to continue several new facility and security improvement projects in the HHH Building.

The total RENT increase is somewhat offset by the major changes being implemented by GSA to the Delegated Authority program. Currently, HHS is billed for "fully serviced" space, and the delegated operation and maintenance (O&M) authority program receives a RENT credit from GSA to cover the cost of standard levels of service that HHS provides to itself. Beginning in FY 2004, GSA will eliminate these RENT credits. Instead, HHS will be charged only a "shell" RENT rate, plus the costs of changes related to build-outs and special services provided by GSA. HHS will be responsible for all repairs, and GSA will be responsible for all equipment replacements.

The decrease in Common Expenses is to cover the increased GDM payment for the Unified Financial Management System (UFMS). The increase in the SSF Payment is attributable to projected inflation rates, and additional services to be provided by the SSF.

UNIFIED FINANCIAL MANAGEMENT SYSTEM
(GDM Payment Only)

	FY 2002 <u>Enacted</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$74,000	\$529,000	\$1,293,000	\$764,000
FTE	—	—	—	—

Purpose and Method of Operations

The Unified Financial Management System (UFMS) represents a key endeavor under Secretary Thompson's "One HHS" management approach and vision. The overall purpose of UFMS is to replace the five antiquated, non-integrated financial systems currently in use across the Department with a modern, efficient financial management system. Per the Secretary's directive of June 2001, UFMS will consist of two major components: the Healthcare Integrated General Ledger Accounting System (HIGLAS) for the Centers for Medicare & Medicaid Services (CMS) and a second system for the rest of HHS. The vision for UFMS is as follows: "The Department shall have an integrated Department-wide financial system that consistently produces relevant, reliable and timely financial information to support decision-making and cost-effective business operations at all levels throughout the Department."

The UFMS Program is overseen by the UFMS Program Management Office (PMO). The PMO is headed by the UFMS Program Director and is located in the Office of the Assistant Secretary for Budget, Technology and Finance (ASBTF). The PMO manages the day-to-day UFMS program operations and activities, within the guidance and direction provided by the ASBTF and the UFMS governance bodies – the UFMS Steering Committee and the UFMS Planning and Development Committee.

The Department launched the UFMS Program in late FY 2001. Following are the principal accomplishments for the Program to date:

- Hired independent verification and validation (IV&V) contractor (September 2001)
- Hired systems integrator (November 2001)
- Hired UFMS Program Director (December 2001)
- Established UFMS PMO (January 2002)
- Developed Department-wide requirements for financial system (April 2002)
- Established executive governance structure (April 2002)
- Developed Department-wide budget and accounting classification structure (BACS) (April 2002)
- Developed UFMS Risk Assessment and Mitigation Plan (May 2002)

- Established "sandbox" UFMS testing capability (May 2002)
- Developed change management plan (June 2002)
- Developed organization and staffing plan (July 2002)
- Developed core financial system Target Business Model (July 2002)
- Developed performance measurement plan (July 2002)
- Developed core financial system Target Business Model (July 2002)
- Began coordinating UFMS activities with Department-wide travel system activities; defined HHS-wide travel system requirements (August 2002)
- Finalized UFMS Implementation Plan and delivered it to OMB (September 2002)
- Finalized UFMS Business Case and estimated return on investment calculations, for presentation to the HHS Information Technology Investment Review Board (ITIRB) (November 2002)
- UFMS Global Team completed systems requirements review sessions with OPDIVs (January 2003)

The PMO has begun global design activities to develop and test the system configurations, interfaces with pertinent HHS administrative systems (i.e., "feeder systems" to UFMS), and standard processes to be employed once UFMS is implemented. These activities will be carried out by the PMO and the system integrator, with participation from all of the OPDIVs.

In FY 2004, the UFMS Program will enter its second year of detailed implementation activities. Per the UFMS Implementation Plan, as approved by the Department in September 2002, various system implementation activities will be occurring across the OPDIVs. Funding will be used to carry out the planned implementation activities and to acquire requisite assets (such as hardware and software licenses) and other related services (e.g., software maintenance and information technology support, training, independent validation and verification, program management and support, etc.). The PMO will manage and oversee the execution of UFMS Program funds.

During FY 2004, the following implementation activities are to be performed at the OPDIV level:

- *CDC*: Completion of validation and testing of UFMS at CDC locations; deployment of the system and training of users. Per the UFMS Implementation Plan, UFMS should be fully implemented at CDC by October 2004.
- *FDA*: Validation and testing of the system, with implementation of the general ledger functionality by October 2004.
- *Program Support Center (PSC) and its customer agencies*: Validation and testing of the system at two "pilot" customer agencies; "ramping up" and preparing for implementation of the system at other agencies.

Rationale for the Budget Request

The FY 2004 request for the GDM payment to UFMS is \$1,293,000, an increase of \$764,000 over the FY 2003 President's Budget request. (NOTE: An additional \$500,000 for the staff costs of the PMO are included in the ASBTF request).

OFFICE OF THE SECRETARY

UFMS PAYMENTS

	FY 2002 Enacted	FY 2003 Pres Budget	FY 2004 Request	Increase or Decrease
GDM 1/	\$945,000	\$1,029,000	\$1,793,000	+\$764,000
Policy Research ...	-	18,000	45,000	+27,000
OIG	71,000	428,000	1,044,000	+616,000
OCR	2,000	16,000	38,000	+22,000
ASPHEP	-	5,000	11,000	+6,000
SSF	2,000	2,000	6,000	+4,000
TOTAL, OS	\$1,020,000	\$1,498,000	\$2,937,000	+\$1,439,000

1/ Includes costs of the UFMS Program Management Office, which are reflected in the ASBTF request.

HHS SERVICE AND SUPPLY FUND

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$7,854,257	\$7,801,000	\$7,946,000	+\$145,000
FTE	42	42	42	-

Purpose and Method of Operations

This section describes the Office of the Secretary (OS) components funded through the Department's Service and Supply Fund (SSF), which is a revolving fund authorized under 42 USC 231. The SSF provides for consolidated financing and accounting for business-type Operations involving the provision of common services and commodities to customers. The SSF does not have its own appropriation, but is funded entirely through charges to the HHS operating agencies, as well as other Federal agencies and departments, for their usage of goods and services. The FY 2004 budget request for the OS portion of the SSF is estimated at \$7.9 million, which will support 42 full-time equivalent positions (FTE).

The OS SSF activities include:

Regional Health Administrators (RHAs)

- Act as liaison for the Secretary and Assistant Secretary with Federal, State and local health officials.
- Coordinate the HHS health-related programs and act as a facilitator for strengthening the public health infrastructure and public health policy related to these programs.

Departmental Contracts Information System (DCIS)

- Compile contract information to produce geographically based reports for the Office of Management and Budget (OMB) and Congress.
- Provide data for Freedom of Information Act (FOIA) requests from OMB, the Congress, State governments, and HHS management.

Tracking Accountability in Government Grants System (TAGGS)

- Compile grant information for HHS management, including application, award, financial, and accounting information.

- Support interagency efforts that will directly benefit every Federal agency involved in making grants to a variety of recipients, including State and local governments, Tribes, universities, research institutions, nonprofit organizations and others.

Audit Resolution

- Resolve audit findings on grantee and contractor organizations which affect programs of more than one HHS OPDIV or Federal agency.
- Recommend corrections to deficiencies in overall accounting systems, internal controls or other management systems.
- Provide functional leadership for completing and coordinating with the Office of the Inspector General the Annual Management Report on Final Action to Congress on audit findings.

PSC Operations and Management Staff

- Provides leadership and policy direction to the activities of the Program Support Center.

Fund Manager Policy Support Staff

- Provide analytical and decision support to the Funds' Board of Directors; advise the Board on fiscal implications of its policies and decisions.
- Provide Fund-wide direction for financial management, budget, fee-for-service development, etc.

Rationale for the Budget Request

The FY 2004 request for OS Service and Supply Fund components is an increase of \$145,000 above FY 2003 levels. The increase reflects the funds needed to cover increased costs such as the annualization of the January 2003 pay raise, the anticipated January 2004 pay raise, and other increases.

HHS SERVICE AND SUPPLY FUND

OFFICE OF THE SECRETARY SERVICE PROVIDERS
ESTIMATED FY 2004 REVENUE BY CUSTOMER
(Dollars in thousands)

Operating Agencies	Regional Health Administrators	DCIS	TAGGS	Audit Resolution	Total ¹
CMS	\$-	\$29	\$84	\$177	\$290
ACF	-	- 7	19	383	- 409
AoA	-	- 1	7	- 40	48
HRSA	- 949	30	154	- 17	-1,150
IHS	- 542	169	73	- 15	- 799
FDA	- 542	81	22	1	646
CDC	542	140	79	- 24	- 785
NIH	542	198	296	248	-1,284
SAMHSA	542	-15	91	- 26	- 674
AHRQ	542	7	8	--	557
OS	542	21	8	-	571
TOTAL	\$4,743	\$698	\$841	\$931	\$7,213

¹ Total excludes costs of PSC Operations & Management (\$149) and Fund Manager support staff (\$584). Fund Manager costs are spread over all SSF activities, and PSC Operations & Management costs are spread over all PSC activities as overhead charges.

HIV/AIDS IN MINORITY COMMUNITIES

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$49,991,000	\$50,000,000	\$50,000,000	\$-
FTE	-	-	-	-

Purpose and Method of Operations

In 1999, the Congressional Black Caucus initiated a partnership with the Department to significantly increase the national response to the HIV/AIDS epidemic in racial and ethnic minority communities. The disproportional impact of this epidemic on these populations warranted a new HIV/AIDS campaign. The partnership identified the following issues as priority:

- to develop more effective prevention education interventions;
- to increase access to HIV counseling and testing services; and
- to ensure that comprehensive and quality health care and drug abuse treatment services are available in these communities.

Since FY 1999, \$50,000,000 has been appropriated each year to support the Minority HIV/AIDS Initiative (MAI). Utilizing these funds, significant steps have been taken to respond to this unfolding crisis through capacity enhancements to mount a community-based response, delivering prevention and treatment services, and providing guided and informed technical assistance and research. A sustained commitment to these goals must be maintained to ensure a durable response – with a flexible resource pool that can be quickly targeted to respond to newly emerging problems – and to capitalize on lessons learned. These targeted investments have been successful in identifying and addressing key barriers to allowing the Department's programs to effectively reach and serve communities of color.

Rationale for the Budget Request

The HIV/AIDS in Minority Communities Program identifies and supports innovative approaches for reducing the HIV/AIDS crisis in minority communities. Accordingly, the FY 2004 request includes \$50,000,000 for the Secretary to transfer to the HHS public health agencies for specific program activities. These resources will provide the Department with a means of addressing underlying issues that have frustrated effective public health responses to the epidemic in minority communities, which crosscut narrower focus areas of Agency-specific programming.

HIV/AIDS IN MINORITY COMMUNITIES

Funding Allocation
(Dollars in thousands)

Agency	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003 ¹	FY 2004 ¹
CDC	\$21,000	\$20,045	\$16,450	\$15,641		
SAMHSA	12,500	12,000	11,500	12,000		
HRSA	5,800	5,000	6,100	6,200		
NIH	2,700	1,200	—	—		
IHS	—	750	1,100	1,450		
OS	8,000	10,600	15,050	14,700		
OPHS:						
OHAP	2,500	3,000	3,420	3,200		
OMH	5,000	6,500	7,800	7,900		
OPA	500	600	3,000	3,000		
OWH	—	500	500	600		
ASPE	—	—	330	—		
TOTAL	\$50,000	\$50,000	\$50,000	\$49,991	\$50,000	\$50,000

¹ Allocation to be determined.

INFORMATION TECHNOLOGY SECURITY AND INNOVATION FUND

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$21,960,000	\$20,000,000	\$18,400,000	-\$1,600,000
FTE	-	-	-	-

Purpose and Method of Operations

The Department's information technology (IT) systems are highly decentralized and heterogeneous, and therefore vulnerable to exploitation. The IT Security and Innovation Fund finances projects consistent with Secretary Thompson's May 24, 2001, "Statement of Direction Regarding Information Technology," in which he stated his goal of managing the Department's IT on an enterprise basis. Therefore, projects funded through the IT Fund focus on HHS enterprise-wide investments, notably: enterprise architecture, key E-Government projects, HHS common IT infrastructure services, and security and infrastructure to enable common administrative systems.

These enterprise elements are critically important to the goal of consolidating across "One HHS." In addition, through the consolidation of IT assets, HHS can eliminate unnecessary duplication of resources and efforts, while simultaneously ensuring an appropriate level of redundancy for continuous, robust, reliable operations. Continuous modernization of processes, practices, and systems will result in improved services to citizens, customers, and stakeholders.

The IT Fund gives priority to projects which meet one or more of the following criteria: have value to more than one HHS Operating Division; support the President's Management Agenda; integrate existing functions; promote security; reduce costs; and increase interoperability. The IT Fund ensures that all projects meet HHS and US standards for capital investment, are approved by the Department's IT Investment Review Board (ITIRB), conform to the HHS Enterprise Architecture, and have a system of accountability and performance measurement in their project plans.

The IT Fund also assists the Department in conforming with the Clinger-Cohen Act, the Government Information Security Reform Act (GISRA), Critical Infrastructure Protection (CIP) requirements, OMB Circulars A-127 and A-130, NIST security guidelines, and Section 508 of the Disabilities Act.

The IT Fund was first appropriated in FY 2002; those monies were used to support the following accomplishments:

- Cyber-intelligence warnings available.
- Installation of multi-tier computer virus protection.
- Initiation of security training, and certification of 32 IT professionals.
- Completion of an Enterprise security risk assessment.
- Completion of a baseline inventory of current FTS2001 and other long-haul communications circuits.
- Completion of an IT hardware asset inventory.
- Finalization of a PKI assessment, in coordination with the Federal E-Authentication Program.
- Completion and rollout of the Enterprise Human Resources and Payroll program (EHRP).

Rationale for the Budget Request

The FY 2004 request for the IT Security and Innovation Fund is \$18,400,000, a decrease of \$1,600,000 below the FY 2003 level. This decrease reflects the elimination of funding for Configuration Management, which will be captured under Enterprise Architecture, and maintaining Section 508 funding at current levels. In addition, savings have been achieved from the completion and rollout of the EHRP in FY 2002. Therefore, EHRP has been eliminated (except for maintenance) from the IT major projects list and the FY 2003-2006 IT 5-Year Strategic Plan as a new development.

For FY 2003 and FY 2004, the IT Fund will be used to enable the OPDIVs to have an enterprise perspective, including:

- Implementation of an E-Gov model.
- Completion of a Common Enterprise Architecture Model.
- Deployment of a simple, unified e-grants application mechanism.
- Initial launch of an Enterprise Information portal (intranet).
- Implementation a fully-integrated, cost-effective HHS network.
- Completion of Consortium IT functions and infrastructure consolidation.
- Consolidation of key IT services, both within OPDIVs and across the Department.
- Issuance of HHS PKI operational certificates to HHS subscribers.

Each OPDIV must justify its requests to utilize Fund resources through the Department's ITIRB process. The highest priority IT projects, as determined by the ITIRB, will receive funding.

In addition to the projects listed in the HHS Enterprise IT Strategic Plan for FY 2003-FY 2006 which may seek additional funding (e.g., Enterprise Architecture, Web Portals, IT Consolidation, IT Security, Network Modernization, Enterprise Directory, PKI, E-Grants), there is also the possibility that other projects may seek funding support.

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>
Immediate Office of the Secretary	69	69	68
Public Affairs	33	35	34
Legislation	26	28	28
Planning and Evaluation	79	95	95
Budget, Technology and Finance	129	144	148
Administration and Management	131	156	150
Intergovernmental Affairs	40	47	45
General Counsel	347	344	342
Departmental Appeals Board	72	76	73
Office on Disability	—	3	3
Global Health Affairs	55	56	56
Public Health and Science	299	312	312
President's Council on Bioethics	<u>10</u>	<u>10</u>	<u>10</u>
Total, GDM (excluding SSF)	1,290	1,375	1,364

Average GS Grade

2000	12.0
2001	12.1
2002	12.1
2003	12.1
2004	12.1

General Departmental Management

DETAIL OF POSITIONS

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>
Executive Level I	1	1	1
Executive Level II	1	1	1
Executive Level III	-	-	-
Executive Level IV	6	6	6
Executive Level V	<u>-</u>	<u>-</u>	<u>-</u>
Subtotal	8	8	8
Total - Executive Level Salaries	\$1,096,700	\$1,134,800	\$1,160,600
ES-6	-	-	-
ES-5	5	6	6
ES-4	22	22	22
ES-3	11	11	11
ES-2	13	13	13
ES-1	<u>20</u>	<u>20</u>	<u>20</u>
Subtotal	71	72	72
Total - ES Salaries	\$8,664,200	\$8,965,300	\$9,169,200
GS-15	240	255	253
GS-14	363	386	383
GS-13	195	207	206
GS-12	125	133	132
GS-11	92	98	97
GS-10	11	12	12
GS-09	117	124	124
GS-08	64	68	68
GS-07	69	73	73
GS-06	28	30	30
GS-05	19	20	20
GS-04	19	20	20
GS-03	2	2	2
GS-02	1	1	1
GS-01	<u>-</u>	<u>-</u>	<u>-</u>
Subtotal	1,345	1,431	1,420
Commissioned Corps	93	99	98
Ungraded	<u>35</u>	<u>37</u>	<u>37</u>
Total positions	1,552	1,647	1,635

General Departmental Management

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>
Total FTE usage, end of year	1,332	1,417	1,406
Average ES level	3	3	3
Average ES salary	\$122,031	\$126,272	\$129,144
Average GS grade	12.1	12.1	12.1
Average GS salary	\$65,179	\$67,444	\$68,978
Average Special Pay (Commissioned Corps)	\$76,279	\$78,929	\$80,725
Average Ungraded	\$41,981	\$43,440	\$44,428

NEW POSITIONS REQUESTED

FY 2004

<u>Positions</u>	<u>Grade</u>	<u>Number</u>	<u>Annual Salary</u>
None	-	-	-

CENTRALLY-MANAGED PROJECTS

The GDM Staff Divisions are responsible for administering certain centrally-managed projects on behalf of all Operating Divisions in the Department. Authority for carrying out these efforts is authorized by either specific statute or general transfer authority (such as the Economy Act, 31 USC 1535). The costs for centrally-managed projects are allocated among the Operating Divisions in proportion to the estimated benefit to be derived.

PROJECT	DESCRIPTION	FUNDING
Quality of Work Life Initiative	The Quality of Work Life (QWL) Initiative supports the Work/Life Center at HHS headquarters; the QWL Internet site on the HHS Home Page; an annual survey of HHS employees; the Department-wide Conference on Diversity and the Secretary's Conference on Family-Friendly Work Practices; activities of the HHS Union-Management Partnership Council; and consultation and skills training to human resource management professionals and change agents throughout HHS.	\$714,000
National Rural Development Partnership	These monies fund HHS's participation in the National Rural Development Partnership, which is managed by USDA's Rural Development Administration and involves all Cabinet Departments except State and Justice. Under this initiative, over 40 States have developed State Rural Development Councils to support rural development, based on the principles of cooperation between Federal, State, and local governments.	\$422,000
IT Access for the Disabled	These funds ensure that HHS complies with the requirements of Section 508 of the Rehabilitation Act Amendments: a baseline of current compliance and vulnerabilities is being established; governance rules for Section 508 are being developed; and a comprehensive program is being implemented which should become a part of the HHS infrastructure in the same manner that EEO requirements and programs have.	\$204,000

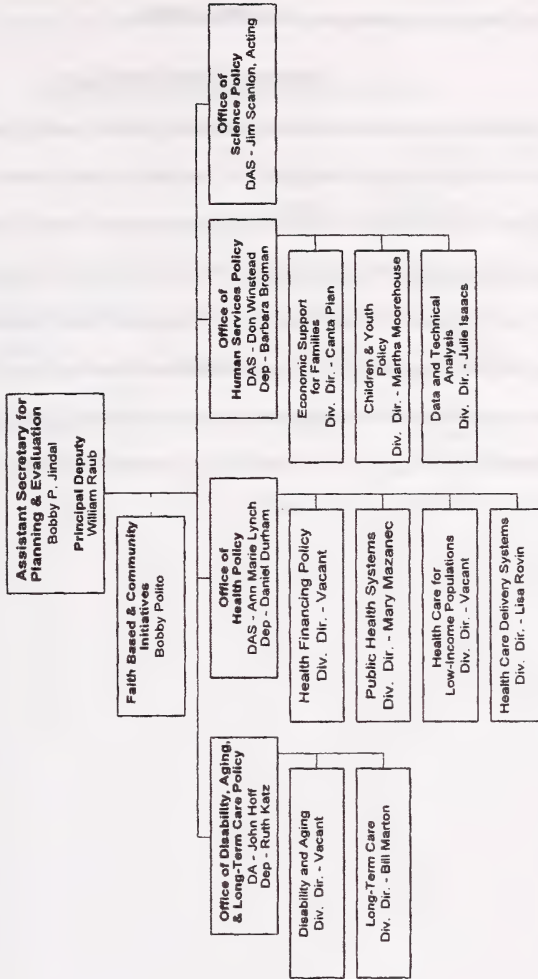
General Departmental Management

Media Outreach	These funds are used to expand the production and distribution of (1) public service announcements and video news reports for air time on TV and radio, including in Spanish, and (2) media fact books and health care kits directed to disadvantaged and minority audiences.	\$75,000
Energy Program Review	The Energy Program Review funds a private contractor to evaluate the status of Operating Division energy conservation programs, and to update existing policies to ensure Departmental compliance with Federal laws and regulations.	\$50,000
Safety, Health, and Environmental Programs	The Safety, Health, and Environmental Program enables the Department to continue conducting safety and occupational health program evaluations and environmental compliance assessments necessary to ensure that HHS employees have a safe and healthful working environment as required by statute.	\$42,000
HHS Health and Wellness Center	The HHS Health and Wellness Center funds are used to provide a portion of the ongoing operating costs of a health facility which promotes physical fitness for all HHS employees located in the Southwest Complex.	\$37,000
Safety Management Information System	The SMIS is a Department-wide accident and injury reporting and analysis system which enables HHS to verify the accuracy of Worker's Compensation claims charged by the Department of Labor (DOL); it also assists in accident prevention efforts required by DOL and Executive Order 12196, and identifies deficiencies in HHS's accident prevention program.	\$12,000
TOTAL		\$1,556,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
POLICY RESEARCH

<u>FY 2004 Budget</u>	<u>Page</u>
Organization Chart	168
Appropriation Language	169
Amounts Available for Obligation	170
Summary of Changes	171
Budget Authority by Activity	172
Budget Authority by Object	173
Salaries and Expenses	174
Authorizing Legislation	175
Appropriations History Table	176
Justification:	
General Statement	177
State Innovation Fund	178
Human Services Policy	179
Health Policy	181
Disability, Aging, and Long-term Care Policy	181
Science and Data Policy	183
National Electronic Health Information Initiative	184
Policy Support	185
Poverty Research Centers	185
Detail of Full-Time Equivalent (FTE) Employment	187
Detail of Positions	188

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION



APPROPRIATION LANGUAGE

For carrying out, to the extent not otherwise provided, research studies under section 1110 of the Social Security Act and title III of the Public Health Service Act [\$2,500,000] \$2,499,000: *Provided*, That in addition to amounts provided herein, [funds] \$21,000,000 shall be available from amounts available under section 241 of the Public Health Service Act [may be used] to carry out national health or human services research and evaluation activities: *Provided further*, That the expenditure of any funds available under section 241 of the Public Health Service Act are subject to the requirements of section 205 of this Act. (*Department of Health and Human Services Appropriations Act, 2002, as enacted by Title II of PL 107-116.*)

AMOUNTS AVAILABLE FOR OBLIGATION¹

	FY 2002 <u>Actual</u>	FY 2003 President's <u>Budget</u>	FY 2004 <u>Estimate</u>
<u>General funds:</u>			
Annual appropriation	\$2,500,000	\$2,499,000	\$2,499,000
Rescission pursuant to PL 107-206	<u>-6,000</u>		
Adjusted Budget Authority	2,494,000	2,499,000	2,499,000
Unobligated balance lapsing	<u>-1,000</u>	<u>—</u>	<u>—</u>
Total obligations	\$2,493,000	\$2,499,000	\$2,499,000

¹ Excludes the following amounts for reimbursable activities carried out by this account: FY 2002 – \$24,682,000; FY 2003 – \$27,500,000; FY 2004 – \$30,500,000.

SUMMARY OF CHANGES

2003	Request – General funds	\$2,499,000
	Total estimated budget authority	2,499,000
2004	Request – General funds	\$2,499,000
	Total estimated budget authority	2,499,000
	Net change	\$ -

	2003		Change from Base	
	<u>President's Budget</u>		<u>Budget</u>	
	<u>(FTE)</u>	<u>Authority</u>	<u>(FTE)</u>	<u>Authority</u>
<u>Increases:</u>				
A. <u>Built-in:</u>				
1. Salaries		\$-	(-)	\$ -
2. Benefits			(-)	=
Subtotal				-
B. <u>Program:</u>				
1. All other		2,494,000	=	=
Total increases				
Net change			(-)	\$ -

BUDGET AUTHORITY BY ACTIVITY
(Dollars in thousands)

	FY 2002 <u>Actual</u>		FY 2003 President's <u>Budget</u>		FY 2004 <u>Estimate</u>	
	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>
Total budget authority	47	\$2,494	47	\$2,499	47	\$2,499

BUDGET AUTHORITY BY OBJECT

	FY 2003 President's <u>Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
FTE employment (reimbursables)	47	47	-
Average SES salary	\$-	\$-	\$-
Average GS grade	-	-	-
Average GS salary	\$-	\$-	\$-
Personnel compensation:			
Full-time permanent	\$-	\$-	-\$-
Other than full-time permanent	-	-	-
Other personnel compensation	=	=	=
Subtotal	-	-	-
Civilian personnel benefits	-	-	-
Benefits to former personnel	=	=	=
Subtotal, pay costs	-	-	-
Travel	-	-	-
Transportation of things	-	-	-
Rental payments to GSA	-	-	-
Communications, utilities, miscellaneous charges	-	-	-
Printing and reproduction	-	-	-
Other services	-	-	-
Purchases of goods and services from Government accounts	-	-	-
Research and development contracts	-	-	-
Subtotal, other contractual services	-	-	-
Supplies and materials	-	-	-
Equipment	-	-	-
Grants, subsidies and contributions	<u>2,499,000</u>	<u>2,499,000</u>	<u>-</u>
Subtotal, non-pay costs	2,499,000	2,499,000	-
Total budget authority	\$2,499,000	\$2,499,000	-

SALARIES AND EXPENSES
(Budget Authority)

	FY 2003 President's Budget	FY 2004 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	\$-	\$-	\$-
Other than full-time permanent (11.3)	-	-	-
Other personnel compensation (11.5/11.8)	-	-	-
Subtotal, personnel compensation (11.9)	-	-	-
Civilian personnel benefits (12.1)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Subtotal, pay costs	-	-	-
Travel (21.0)	-	-	-
Transportation of things (22.0)	-	-	-
Rental payments to others (23.2)	-	-	-
Communications, utilities, miscellaneous charges (23.3)	-	-	-
Printing and reproduction (24.0)	-	-	-
Other contractual services:			
Advisory and assistance services (25.1)	-	-	-
Other services (25.2)	-	-	-
Purchases of goods and services from Government accounts (25.3)	-	-	-
Operation and maintenance of facilities (25.4)	-	-	-
Research and development contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-
Subsistence and support of persons (25.8)	-	-	-
Subtotal, other contractual services	-	-	-
Supplies and materials (26.0)	-	-	-
Subtotal, non-pay costs	-	-	-
Total Salaries and Expenses	\$ -	\$ -	\$ -

AUTHORIZING LEGISLATION

	2003 Amount <u>Authorized</u>	2003 President's <u>Budget</u>	2004 Amount <u>Authorized</u>	2004 Budget <u>Request</u>
Policy Research (BA) . . .	Indefinite	\$2,499,000	Indefinite	\$2,499,000
Evaluation funds (reimbursable)	Indefinite	\$18,000,000	Indefinite	\$21,000,000

APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
<u>FY 1995</u>				
Appropriation	\$13,000,000	\$13,659,000	\$-	\$13,659,000
Rescissions	-	-	-	-4,032,000
SSA Transfer	-	-	-	-244,000
<u>FY 1996</u>				
Appropriation	9,000,000	9,000,000	-	9,000,000
Rescission	-	-	-	-32,000
<u>FY 1997</u>				
Appropriation	9,000,000	9,000,000	18,500,000	18,500,000
Rescission	-	-	-	-14,000
<u>FY 1998</u>				
Appropriation	9,000,000	14,000,000	9,500,000	13,974,000
<u>FY 1999</u>				
Appropriation	14,000,000	14,000,000	14,000,000	14,000,000
Rescission	-	-	-	-9,000
<u>FY 2000</u>				
Appropriation	14,000,000	14,000,000	15,000,000	17,000,000
Rescission	-	-	-	-262,000
<u>FY 2001</u>				
Appropriation	16,738,000	16,738,000	16,738,000	16,738,000
Rescission	-	-	-	-23,000
<u>FY 2002</u>				
Appropriation	2,500,000	2,500,000	2,500,000	2,500,000
Rescission	-	-	-	-6,000
<u>FY 2003</u>				
Appropriation	2,499,000			
<u>FY 2004</u>				
Appropriation	2,499,000			

POLICY RESEARCH

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$2,494,000	\$2,499,000	\$2,499,000	\$-
Evaluation funds (reimbursable)	<u>18,000,000</u>	<u>18,000,000</u>	<u>21,000,000</u>	<u>+3,000,000</u>
Total, Program Level	\$20,494,000	\$20,499,000	\$23,499,000	+\$3,000,000
FTE	47	47	47	--

GENERAL STATEMENT

The Policy Research program examines broad issues that cut across agency and subject lines, as well as new policy approaches developed outside the context of existing programs. It has three broad goals: first, to provide policy-relevant information on national trends in public and private health and human service programs; second, to analyze the potential costs and benefits of proposed public sector policy changes to these programs; and third, to identify emerging policy issues and potential solutions.

The need for coordinated, objective, and high-quality policy research and data collection and analysis is especially important in light of the dramatic changes now occurring in health care and human services. The Policy Research program is critical to meeting this need. The requested funding level will support expanded research on the many issues raised by recent major changes in health and human services programs; for instance, the reform of the welfare system and the need to modernize Medicare. Specifically, the FY 2004 request level of \$23,499,000 will support work on the following priority themes identified by the Secretary:

State Innovation: Supporting State demonstrations of ways to better deliver effective health and human services.

Working Toward Independence: Supporting research on how to promote work and self-sufficiency, especially on the part of welfare families and the working poor, and increase the control over services and quality of life for people with disabilities.

Leaving No Child Behind: Studying ways to improve school readiness as a critical component of comprehensive early childhood education.

Promoting Active Aging and Improving Long-Term Care: Encouraging individual planning

for age-related health and long-term care needs and improving post acute care service delivery, organization, and outcomes.

Protecting and Empowering Specific Populations: Promoting research/demonstration activities for special populations such as persons with disabilities, mental illness, and addictions.

Helping the Uninsured and Increasing Access to Health Insurance: Identifying effective ways to promote State innovation and increase access to insurance through market-based solutions.

Realizing the Possibilities of 21st Century Health Care: Studying ways to improve the electronic health information infrastructure and reduce medical errors.

Protecting Our Homeland: Assessing the preparedness of our public health system to respond to a bioterrorism attack.

Closing the Gaps in Health Care: Developing options for modernizing Medicare and expanding access to health care services, especially for those groups with significant health disparities.

In addition, in FY 2003 and FY 2004 ASPE plans to pursue evaluations to support program performance information needs identified by the Performance Assessment Rating Tool (PART) analysis for several programs, including CDC Childhood Immunizations, HRSA Nursing Loan Repayment, Brief Intervention under the President's Drug Treatment Initiative, and IHS Sanitation Facilities. Final appropriated funding for Policy Research during the last five years has been as follows:

<u>Fiscal Year</u>	<u>Funds</u>	<u>FTE</u>
1999	\$13,987,000	28
2000	\$16,735,000	29
2001	\$16,548,000	29
2002	\$2,494,000	—
2003	\$2,499,000	—

State Innovation Fund

The third year of funding on planning and demonstration grants to allow States to design, demonstrate, and evaluate new models for delivering health and/or human services at the community level to low-income adults, families, and children. The focus of the grants will include, but will not be limited to, the following areas: providing health care to the working poor; facilitating access to health care for the uninsured; providing services to the disabled and aged, children and youth, and working families (especially the hard-to-serve); enhancing gateways to services (e.g., schools and faith-based entities); providing other essential services

(e.g., child care and respite care); and promoting family formation, responsible fatherhood, and responsible child-rearing in the context of marriage. States will be encouraged to integrate separate but related services funded by different programs and/or provided by different agencies. States will be required to include measurable indicators of performance to facilitate evaluation of the outcomes of the demonstrations.

In FY 2004, the planned major accomplishment for the State Innovation Fund is that the Office of the Assistant Secretary for Planning and Evaluation (ASPE) will facilitate information exchange among the grantees, other States, and others interested in new and creative ways to deliver health and/or human services.

Human Services Policy

Human services policy research focuses on issues related to low-income populations and includes analyses of the impacts of changes in demographic and economic characteristics on programs that serve these populations. It includes analyses of the impacts and outcomes of welfare reform, particularly on low-income families with children. Major themes include exploring programs and practices that strengthen families and support them as they move from welfare to work and self-sufficiency; analyzing the impacts of cash assistance, child support, and work support program changes on the demographic and economic characteristics of the low-income population, including poverty; increasing personal responsibility; and exploring challenges faced by low-income children, youth, and families – including child care, school readiness, child abuse and neglect, domestic violence, exposure to drugs and alcohol, physical and mental health issues, child welfare issues, homelessness, out-of-wedlock childbearing (especially among teens), and youth violence. Studies and data to monitor the well-being of children at both the State and national levels are also a high priority.

In FY 2004, planned major accomplishments for Human Services Policy are as follows:

- Building State capacity for designing and conducting high-quality research and evaluations of State and local programs serving low-income populations, and assessing the effects of welfare reform on current, former, and potential welfare recipients and other special and hard-to-serve populations (e.g., those with mental health and substance abuse problems and people with disabilities) affected by State TANF policies.
- Creating an integrated picture of the low-income population, especially low-income families with children, combined with broader analyses of the economic condition, health and well-being, socio-demographic characteristics, and the social service needs of low-income individuals, families, and children.
- Studying and disseminating information about the well-being of children and youth and assessing the effects and impacts of welfare reform policies (e.g., time limits, work requirements and strategies to increase personal responsibility) and changing labor

markets on employment, poverty, family composition, and child well-being.

- Continuing cross-cutting research into the outcomes of welfare reform on current, former, and potential TANF recipients with respect to employment rates, earnings, sources of income, use and awareness of other public assistance programs and work support programs and services (including Medicaid and food stamps), and overall child and family well-being (including such areas as food, health and housing insecurity, child care, foster care, and domestic violence).
- Understanding the demographics and poverty dynamics of those who are neither receiving cash assistance nor employed, and the extent to which different populations are served by existing programs and/or could be better served; examining issues related to the measurement of poverty, including the extent to which it accurately captures the economic well-being of low-income individuals, families and children and the implications of alternative poverty measures.
- Promoting, enhancing, and supporting State and local capacity for designing and conducting data collection and monitoring studies to facilitate States' monitoring of outcomes for their own State and local populations. Activities could include state-level data collection efforts (using both administrative data and surveys), administrative data linking, the creation of public-use and restricted-access data files, and fostering linkages with programs to improve the quality of research results and ensure more uniformity and comparability across studies.
- Enhancing job retention and advancement for those moving from welfare to work and self-sufficiency; and providing critical supports for poor and low-wage workers who face barriers to success in the labor market
- Supporting and enhancing research, services, and approaches to strengthen and support present and future families, including activities to prevent out-of-wedlock pregnancies, especially among teens.
- Supporting and enhancing research, services, and approaches to promote children's social capabilities, emotional health, cognitive development, physical health, and school readiness.
- Understanding and measuring the impacts and outcomes of welfare reform on child and youth well-being and development, continuing research to improve development and use, particularly at the State level, of indicators of child well-being (including school readiness indicators), and continuing annual reports on the well-being of children and youth.
- Supporting research and activities related to national child support enforcement

programs, including compliance, child well-being, custody, and visitation, father involvement, paternity establishment, and enhanced enforcement.

- Continuing and enhancing research, services, and approaches to helping hard-to-serve and special populations (e.g., persons with disabilities and mental illness, victims of domestic violence, substance abusers, immigrants, and Native Americans) move from welfare to work and self-sufficiency.
- Continuing the annual report to Congress on indicators of welfare dependence.

Health Policy

Health Policy research includes health care financing and public health issues. One major focus will be the modernization of Medicare and improving Medicaid services. Another major focus will be to examine options for encouraging private health plan participation in public programs.

In FY 2004, planned major accomplishments for Health Policy include:

- Examining ways to increase access to health insurance through market-based solutions;
- Developing new policy initiatives to improve access to health services and provide more consumer choice in major departmental health programs such as Medicare and Medicaid;
- Assessing the implementation and effectiveness of the State Children's Health Insurance Program (SCHIP) in enhancing insurance coverage and improving health quality and outcomes for various populations;
- Understanding the impact on HHS "safety net" programs from changes in health care financing and delivery systems;
- Providing leadership in coordinating health care research across the Department through the Research Coordination Council;
- Improving health data systems and survey information to yield relevant and timely information to Departmental decision-makers; and
- Conducting qualitative and quantitative analysis and coordinating cross-cutting health policy issues and assure their integration into the regulatory processes, legislative proposals and other policy support activities required by the Secretary.

Disability, Aging, and Long-Term Care Policy

Disability, Aging, and Long-Term Care research and analysis will continue to address the health care and long-term support needs of individuals with chronic illness and disability. A major theme of the Disability, Aging and Long-Term Care Policy research agenda is the production of information which can be used by States, communities, and consumers, to increase the availability and affordability of an array of high-quality long-term care services and reduce barriers to consumer choice and independence.

In FY 2004, planned major accomplishments for Disability, Aging, and Long-Term Care Policy are as follows:

- Priority will be given to research supporting the development of new public and private programs and practices in States and communities that provide people with disabilities and their families a broader array of community-based support for meeting their long-term care needs. Such research will support the Administration's New Freedom Initiative, which promotes opportunities for independent living and economic self-sufficiency for people with disabilities. In addition, studies will continue to be implemented that examine the impact on access, quality and costs of selected State strategies for increasing access to personal care and other home and community-based services, with an emphasis on expanding opportunities for consumers to exercise the maximum amount of choice and control over their own services.
- Other important areas of emphasis include:
 - Quality in institutional settings: Identifying innovative strategies to improve the quality and delivery of nursing home, post acute care, and assisted living services, while reducing burdensome paperwork requirements on providers. These efforts will be coordinated with the Secretary's Nursing Home Quality Initiative.
 - The Long-Term Care Workforce: Studying State and provider approaches to addressing the shortage of qualified front line long-term care workers; experimenting with strategies for improving their retention and quality; developing and testing new approaches to career development and training; and identifying strategies for improving wages and benefits.
 - Serving Individuals who are dually eligible for Medicaid and Medicare: Identifying and studying State and provider level approaches to serving dual eligibles, particularly those who use both acute and long-term care services. Work will focus on strategies that facilitate consolidation of Medicare and Medicaid funding streams and promote capitation and foster consumer direction.
 - Family Care-Giving: Modeling the implications of the aging of the Baby Boomers

on family care-giving, and the impact on the relationship between formal and informal caregiving.

- **Private Long-Term Care Insurance:** Studying innovative public-private partnerships to finance long-term care; examining the choices insurance claimants make and their satisfaction with their coverage and services; and evaluating the early implementation of the Federal long-term care insurance benefit. Evaluating implications of potential changes in tax treatment of long-term care insurance.
- **Health Coverage and Organization:** Evaluating the impact of alternative financing options for health coverage for low income individuals; studying the satisfaction of physicians (and other health professionals) and the effect on access to care and identifying State and Federal requirements that increase litigation and costs.
- **Conducting Research to Support the Development of an Electronic Health Record:** These analyses will support development of a system of effective clinical management of patient information; improve quality of care; enhance, expand, and support the role of patients in health care decision making; and reduce the regulatory burden imposed on providers. This is an important element of bioterrorism defense.
- **Assessment Forms:** Research and analysis of assessment forms to improve their utility and reduce burden.
- **Data Infrastructure:** Promoting and ensuring the ongoing collection of administrative and survey data to support decision making on long-term care, disability and aging issues. This includes developing, collecting and analyzing longitudinal data to monitor and understand trends and transitions related to these issues.

Science and Data Policy

The focus of the science and data policy research agenda is guiding and coordinating the development of science and data policy throughout the Department, the incorporation of science and data policy considerations within regulatory and legislative proposals, Congressional testimony, press releases and other public documents describing major departmental initiatives. The focus is also to create and maintain effective communication with scientific and technical communities outside the Department regarding science and data policy issues.

In FY 2004, planned major accomplishments for Science and Data Policy are as follows:

- Formulate and coordinate HHS-wide science policy, including strategies to foster further development and responsible applications of genetic testing and xenotransplantation (use of animal cells, tissues, and organs to treat human diseases) and to encourage food safety research relevant to regulatory needs.

- Formulate and coordinate intra- and inter-Departmental efforts to develop and implement strategic approaches to addressing various facets of children's environmental health and its associated concerns, with emphasis on asthma.
- Foster efforts across the Department toward ensuring the science components of proposed regulations, legislation, and other policy initiatives meet the highest standards of science quality and integrity. Where appropriate, exercise such quality control on the science-based portions of documents that form the basis for decision-making by the Secretary, Deputy Secretary, and Chief of Staff.
- Provide leadership and coordination in the development and coordination of HHS wide strategies and plans for data collection, analysis and dissemination activities, data standards and health and human services privacy and confidentiality, and carry out a research program in those areas.
- Coordinate and conduct interagency and gap filling research to promote health applications in the National Information Infrastructure. (See below)
- Coordinate and initiate interagency efforts to improve HHS data systems and statistical resources.
- Provide leadership and staff support for the internal HHS Data Council and the external National Committee on Vital and Health Statistics, the department's external advisory committee for health information policy.

National Electronic Health Information Initiative

This initiative will focus on national electronic health information systems, and builds on work underway since FY 2002. The purpose of this initiative is to accelerate the development and adoption of the technology and national standards necessary for Electronic Health Record Information Systems and their use by the health care and public health systems, as well as related support for the National Health Information Infrastructure (NHII). The initiative involves coordination within HHS and with other Federal agencies, as well as State and industry groups, to: promote the adoption of voluntary standards, develop standards where none exist, expend resources through contracts and grants to acquire or adopt technology and standards, and support the adoption and widespread dissemination of voluntary terminology and messaging standards, as well as such other health data standards as the Secretary may determine necessary. Overall, the activities will contribute to the Secretary's goals of improving the quality and effectiveness of health care, protecting and promoting the health of individuals and families, and strengthening the nation's public health preparedness through improvements in the NHII.

In FY 2004, planned major accomplishments for the National Electronic Health Information Initiative include:

- Coordinating HHS activities relating to the NHII.
- Convening a national meeting with the industry and the public health community to assess progress and identify and disseminate an action agenda for the NHII.
- Establishing and maintaining objective measures of NHII progress.
- Convening meetings with public and private sector partners to facilitate collaboration in NHII development.
- Evaluating and accelerating clinical and related data standards activities to support the NHII

Policy Support

Underpinning the policy research program is a variety of support activities that include simulation modeling, statistical analysis, development and maintenance of databases, and other information services. The goal is to ensure efficient, reliable, and timely analytical support, while offsetting costs through the introduction of cost-saving technologies.

In addition, ASPE is responsible for the HHS-wide strategic, legislative, and research planning. The ASPE chairs the Department's Research Coordination Council (RCC), which was established by the Secretary in the fall of 2001; ASPE also provides key staff for the RCC's workgroups. The RCC encourages agencies to collaborate in the conduct of health services research wherever possible in order to achieve the most efficient and effective use of research resources, and ensures that HHS policy research fully supports the Department's primary mission and objectives. Because ASPE's research and evaluation activities touch on nearly every facet of the Department's research portfolio, its FY 2004 research budget is categorized under "agency-specific priorities."

Poverty Research Centers

ASPE funds national poverty research centers. In FY 2003, this program will be re-competed and multi-year cooperative agreements awarded. These cooperative agreements support research, training and dissemination activities focused on the causes, consequences and remedies of poverty.

In FY 2004, the planned major accomplishment for the Poverty Research Centers are as follows:

- Analyze the causes, consequences and remedies of poverty for the population and subgroups.
- Recruitment, mentoring and training of young poverty scholars and researchers.

- Continual examination and improvement in the methodologies for analyzing poverty and the effectiveness of tax, transfer and service programs serving the poor.

To address the President's Management Agenda, ASPE has focused on organizational consolidation and eliminating management layers. In this respect, ASPE has eliminated one major office through consolidation, and has eliminated a number of unnecessary supervisory positions. Additionally, ASPE has improved its administration of grants by developing a partnership agreement with NICHD to use their grant expertise and electronic technology. ASPE currently outsources much of its research and evaluation studies.

Rationale for the Budget Request

The FY 2004 program level request for Policy Research is the same as the FY 2003 President's Budget level. The FY 2004 request for Policy Research's One Percent Evaluation funds is an increase of \$3,000,000 over the FY 2003 level, to support the National Electronic Health Information Initiative. A redistribution of dollars within the reimbursable non-pay object classes will defray mandatory personnel costs, such as the annualization of the January 2003 pay raise, the anticipated January 2004 pay raise, within-grade increases, and career-ladder promotions.

DETAIL OF FULL-TIME EQUIVALENT (FTE) EMPLOYMENT

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>
Policy Research	-	-	-
Reimbursables	47	47	47

Average GS Grade

1999	13.2
2000	13.3
2001	13.4
2002	14.1
2003	14.1
2004	14.1

DETAIL OF POSITIONS

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>
Executive Level I	-	-	-
Executive Level II	-	-	-
Executive Level III	-	-	-
Executive Level IV	-	-	-
Executive Level V	-	-	-
Subtotal	-	-	-
ES-6	-	-	-
ES-5	-	-	-
ES-4	-	-	-
ES-3	-	-	-
ES-2	-	2	3
ES-1	<u>4</u>	<u>1</u>	<u>-</u>
Subtotal	4	3	3
GS-15	12	12	10
GS-14	15	15	13
GS-13	7	7	7
GS-12	2	2	3
GS-11	1	1	3
GS-10	-	-	-
GS-09	3	3	3
GS-08	1	1	-
GS-07	-	-	-
GS-06	1	1	-
GS-05	-	-	-
GS-04	-	-	-
GS-03	-	-	-
GS-02	-	-	-
GS-01	<u>-</u>	<u>-</u>	<u>-</u>
Subtotal	42	42	39
Ungraded Positions	<u>17</u>	<u>16</u>	<u>16</u>
Total Positions	63	61	58

	FY 2002 <u>Actual</u>	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>
Total FTE usage, end of year	47	47	47
Average ES level	1	2	2
Average ES salary	125,972	136,006	140,630
Average GS grade	14.1	14.1	14.1
Average GS salary	\$78,265	\$80,690	\$83,433

DEPARTMENT OF HEALTH AND HUMAN SERVICES

GPRA PERFORMANCE PLANS
FOR DEPARTMENTAL MANAGEMENT

<u>FY 2004 Budget</u>	<u>Page</u>
Assistant Secretary for Planning and Evaluation	
FY 2004 Performance Plan	192
Assistant Secretary for Budget, Technology and Finance	
FY 2004 Performance Plan	195
Assistant Secretary for Administration and Management	
FY 2004 Performance Plan	216
Departmental Appeals Board	
FY 2004 Performance Plan	234
Office of the General Counsel	
Update on Developing GPRA Performance Measures	243
Office of Public Health and Science	
FY 2004 Performance Plan	244

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

FY 2004 PERFORMANCE PLAN

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary on policy development in health, disability, human services, and science and provides advice and analysis on economic policy. ASPE leads special initiatives on behalf of the Secretary; coordinates the Department's evaluation, research and demonstration activities; and manages cross-Department planning activities such as strategic planning, development of the Departments legislative program and review of regulations. Integral to this role, ASPE conducts research and evaluation studies, develops policy analyses and estimates the cost and benefits of policies and programs under consideration by the Department or the Congress. Reflecting the roles of policy advisor and research foundation, the performance measures are necessarily qualitative.

Performance Goals	FY Targets	Actual Performance	Reference*
1. Provide analytical knowledge (policy research and evaluation studies) and leadership that contributes to the development of sound Department and public policy	FY04: Same as FY03 FY03: Same as FY02 FY02: Same as FY01 FY01: Demonstrated impact of policy analysis and leadership on formulation of public policy.	FY04: FY03: FY02: Objective met FY01: Objective met	
2. Maintain human and technological capacity to respond to planning and analytical needs of the Secretary.	FY04: Same as FY03 FY03: Same as FY02 FY02: Same as FY01 FY01: ASPE analytic support functions made a contribution to the development of analyses for the Secretary. New staff were hired and trained.	FY04: FY03: FY02: Objective met FY01: Objective met	

Preliminary Performance Summary

Establishing Performance Targets: ASPE continues to employ descriptive performance goals to improve its performance over time.

Performance Progress: ASPE reports significant achievements in the activities supporting all of its goals for FY 2002. The following achievements describe ASPE's success in meeting the performance goals stated above.

1. **Analytic Knowledge:** Due to its strong analytic capacity, ASPE continued to play a major role in policy formulation. For example, policy research and evaluation studies in the human services policy arena contributed to the development of the Administration's welfare reform reauthorization principles in at least three areas.

- Findings from the National Evaluation of Welfare to Work Strategies that an employment-focused welfare-to-work approach moved welfare recipients into jobs more quickly than did an education-focused program, supports the “work first” emphasis in the Administration’s principles and the House-passed bill.
- A project to enhance the measurement of child outcomes in five State welfare evaluations focused attention on child health and well-being in State welfare programs and contributed to including child well-being as an overarching purpose of the Temporary Assistance for Needy Families program.
- Additionally, studies on the prevalence of mental health problems and substance abuse among welfare recipients contributed to the inclusion in the Administration’s reauthorization principles of a provision that would allow substitution of substance abuse treatment, rehabilitation, or work-related training for the direct work requirement for three months in any 24-month period.
- Results of the first Federally-sponsored national survey on homelessness led to increased emphasis on improving homeless access and use of mainstream HHS programs and services, through the establishment of the Secretary’s Workgroup on Reducing Chronic Homelessness and a technical assistance program directed to States to help them examine access to mainstream resources for homeless individuals.

Policy research and evaluation studies in the disability, aging and long-term care area have been used to inform a number of legislative and policy decisions:

- Findings from the Cash and Counseling Demonstration and related ASPE studies on consumer direction were used to create the streamlined 1115 and 1915(c) waiver templates for States opting to offer consumer-directed home and community-based services under Medicaid. The Secretary announced these “Independence Plus” templates on May 9, 2002.
- Studies of private long-term care insurance claimants and the services they purchase were used by the Office of Personnel Management in designing the new Federal long-term care insurance benefit.
- “Informal Caregiving: Compassion in Action,” reported what is known about the 52 million Americans who provide informal (i.e., unpaid) assistance to a disabled friend or relative and formed the basis of the Administration on Aging’s Informal Caregiver Support program.
- Findings and data from the project, “Research on Employment Supports for People with Disabilities” were used to develop and modify the 1999 passage of the Ticket to Work and Work Incentives Improvement Act, permitting people with disabilities to return to

competitive employment and still retain insurance coverage.

2. Human and Technological Capacity: In FY 2002, ASPE continued to build a strong analytical capacity. Policy Support Services provided simulation modeling, statistical analysis, and other technical and analytic services needed in order to carry out policy research. The goal was to ensure efficient, reliable, and timely analytic support, while offsetting increases in costs through the introduction of cost-saving technologies. These services support Department-wide data policy and collaboration efforts in data policy, including data standards and privacy, between HHS and the health industry.

ASPE continues to support academic research on poverty and promote secondary analysis of under-utilized but rich data sets.

ASSISTANT SECRETARY FOR BUDGET, TECHNOLOGY AND FINANCE

FY 2004 PERFORMANCE PLAN

The Office of the Assistant Secretary for Budget, Technology and Finance (ASBTF) provides advice and guidance to the Secretary on all aspects of budgetary, financial management, and information technology throughout the Department. The office consists of the following components:

- Immediate Office of the Assistant Secretary
- Office of Budget
- Office of Finance
- Office of Information Resources Management

The ASBTF performance plan for FY 2004 and revised final performance plan for FY 2003 is structured to reflect the categories above. This plan contains 22 performance measures for FY 2004. These measures demonstrate both the Department's commitment to and ASBTF's role in the implementation of the President's Government-wide Management Reforms and the Secretary's additional Management Priorities.

Government-wide Management Reforms

Improve Financial Performance - The FY 2004 ASBTF performance plan includes performance measures addressing the timeliness and reliability of financial information (see Finance Goals 1 and 2).

Expanding Electronic Government - The FY 2004 ASBTF performance plan includes a performance measure to improve the Department's e-gov infrastructure (see Information Resources Management measures 1.7 - 1.10).

Other Management Priorities

Unified Financial Management Systems - The Secretary has established this as a Department-wide management priority. The FY 2004 ASBTF performance plan includes a performance measure to assess progress toward the achievement of this goal (see Finance Goal 3).

Consolidation of HHS Information Technology (IT) Architecture and Enhanced IT Security - The Secretary has established this as a Department-wide management priority. The FY 2004 ASBTF performance plan includes performance measures to assess progress toward the achievement of this goal (see Information Resources Management measures 1.1 - 1.8).

Budget

Performance Goals	FY Targets	Actual Performance	Reference*
Goal 1. Meet the standards of quality and timeliness established by the ASBTF, OMB, Congress and oversight agencies for the annual Budget submission. Prepare clear, concise assessments that articulate HHS OPDIV priorities and meet Department requirements in preparation of the Department's budget.	FY04: Develop FY06 Budget FY03: Develop FY05 Budget FY02: Develop FY04 Budget FY01: New in FY02	FY03: FY02: Objective met	
Goal 2. Provide timely and useful assistance and guidance to OMB and committee staffs and monitor effective implementation of authorizing and other legislation and regulations for Federal budget and management functions; identify and coordinate the resolution of serious issues.	FY04: Oversee FY04 Budget FY03: Oversee FY03 Budget FY02: Oversee FY02 Budget FY01: FY00: Set FY99: Set 11/98	FY03: FY02: Objective met FY01: Objective met FY00: Objective met FY99: Objective met	
Goal 3. Professional management of the appropriation process. Provide high-quality budget justifications to the Appropriations Committees in time for hearings.	FY04: Submit FY05 Budget FY03: Submit FY04 Budget FY02: Submit FY03 Budget FY01: New for FY02	FY03: FY02: Objective met	

Performance Summary

Performance Goal 1: Meet the standards of quality and timeliness established by the ASBTF, OMB, Congress and oversight agencies for annual budget submission. Prepare clear, concise assessments that articulate HHS Operating Agency priorities and meet Department requirements in preparation of the Department's budget.

Performance Objective: The Budget Office provides guidance to Operating Divisions' programs and activities to meet requirements in preparation for budget submission to the President and Congress. This includes the review of agency performance plans, as required by the Government Performance and Results Act, and incorporates performance measurement information into the Departments budget.

Performance Report: During FY 2002, the Budget Office consistently provided timely, accurate, and innovative analysis and information in an environment characterized by competing priorities and non-negotiable deadlines. Briefing materials were succinct, and questions from the Secretary and his staff were answered quickly and accurately.

Performance Target: Met in FY 2002.

Goal 2: Provide timely and useful assistance and guidance to OMB and committee staffs and monitor effective implementation of authorizing and other legislation and regulations for Federal budget and management functions; identify and coordinate the resolution of serious issues.

Performance Objective: The Budget Office provides timely information to the Secretary and his staff in support of compelling justifications to committee staffs in time for their hearings.

Performance Target: Met in FY 2002.

Goal 3: Professional management of the appropriation process. Provide high-quality budget justifications to the Appropriations Committees in time for hearings.

Performance Objective: The Budget Office develops and implements strategies for a timely and effective presentation and defense of the Department's budget during the appropriation process.

Performance Target: New for FY 2002.

Finance

Performance Goals	FY Targets	Actual Performance	Reference*
Goal 1. Submit HHS Performance and Accountability Report (PAR), including consolidated audited financial statements, on time.*			
Measure: Submit the HHS Performance and Accountability Report (PAR)/ consolidated audited financial statements to OMB by the due date.	FY04: November 15, 2004 FY03: February 1, 2004 FY02: February 1, 2003	FY04: FY03: FY02: Jan. 31, 2003	
Goal 2. Earn an unqualified (clean) opinion HHS consolidated financial statements.			
Measure: Results of audit opinion.	FY04: Unqualified FY03: Unqualified FY02: Unqualified	FY04: FY03: FY02: Unqualified	

DM GPRA Performance Plans

Performance Goals	FY Targets	Actual Performance	Reference*
Goal 3. Improve HHS financial management systems to better provide uniform, integrated financial information for all of HHS. Measure: Implement an integrated Department-wide financial system that complies with Federal financial management systems requirements.	FY04: Meet FY04 milestones identified in the detailed implementation plan. FY03: Meet FY03 milestones identified in detailed implementation plan. FY02: Meet FY02 milestones identified in the Project Plan. This includes developing a detailed implementation plan to guide the remaining "life" of the project.	FY04: FY03: FY02: The Unified Financial Management System (UFMS) PMO met the milestones in the high-level project plan for FY02. HHS approved the implementation plan on Sept. 27, delivered to OMB Sept. 30, 2002.	
Goal 4. Maximize the use of electronic payments. Measure: Percentage of payments transferred electronically (Electronic Funds Transfer).	FY04: Vendor = 95% Travel = 100% FY03: Vendor = 95% Travel = 100% FY02: Vendor = 95% Travel = 100%	FY04: FY03: FY02: Vendor = 92% Travel = 98%	
Goal 5. Timely vendor payments Measure: Percentage of vendor payments made on time.	FY04: 97% FY03: 97% FY02: 96%	FY04: FY03: FY02: 98.3%	
Goal 6. Collect debt owed to HHS. Measure: Percent increase in total collections over prior year.	FY04: 10% above total collections for FY 2003 FY03: 10% above total collections for FY 2002 (\$15.8 billion) FY02: 10% above FY01 collection (\$15.8 billion)	FY04: FY03: FY02: Not met (\$14.4 billion)	

DM GPRA Performance Plans

Performance Goals	FY Targets	Actual Performance	Reference*
Goal 7. Improve the Average Time for Resolving Audits under the Single Audit Act. ** Measure: Percent decrease in average time to resolve audits.	FY04: 2.5% decrease from FY03 (129.1 days) FY03: revised, see narrative (132.9 days) FY02: 3% decrease from FY01 (132.9 days) Note: The FY02 target was shown incorrectly as 133.3 on prior report.	FY04: FY03: FY02: Not met (146.4 days)	

NOTE: The targets for the audited financial statement goals match the year covered by the financial statement. The program funding is for the ASBTF/Office of Finance efforts toward these key goals and other supporting functions. Individual HHS agency funding toward these key goals and other supporting functions is included in Exhibit 52 of the submission to OMB.

* Goals 1 and 3 from our previous reports have been combined since the Performance and Accountability Report (goal 3 previously) includes, and cannot be submitted without, the consolidated audited financial statements (goal 1 previously). The targets and actual performance data for FY's 02 - 04 are based on HHS's consolidated financial statements; the same information for the prior FY's, not shown here, was based on the audited financial statements of HHS and its components.

** Beginning in FY 2002, when the Office of Audit Resolution and Cost Policy became part of the Office of Finance. GPRA targets and actual performance for audit resolution became part of the Office of Finance plan.

Narrative: The Office of Finance (OF) provides leadership and guidance on HHS financial management to maintain the confidence of the public that all resources are managed effectively. OF achieves this outcome by ensuring the timely and accurate disbursements, collections and recording of funds and by informing its customers, i.e., decision-makers and the taxpayers with useful financial information.

The OF is committed to achieving two HHS financial management strategic goals:

1. Decision-makers have timely, accurate and useful program and financial information.
- 2: All HHS resources are used appropriately and effectively.

ASBTF/Finance will accomplish these goals in partnership with the HHS components, the government-wide Chief Financial Officers Council (through its various committees and work

groups) and the central agencies including OMB, Treasury, etc. The Office of Finance will utilize these key results to achieve its long-range performance goals which include development of an integrated process capturing financial, budget and program performance information and which make financial information more useful for program managers.

Performance Summary

Performance Goal 1. Timely Audited Financial Statements

Establishing Performance Targets: With the passage of the Reports Consolidation Act of 2000, the authorization of Accountability Reports is now permanent with the reports due February 1 for FY 2002. The report streamlines various individual reports that are required under other legislation and presents the finance, program and budget information in a way that is more useful to the public and to decision-makers.

Discussion of FY 2002, FY 2003 and FY 2004 targets: As the due date continues to accelerate, it will be more challenging. The FY 2002 Accountability Report incorporates the Department's annual Performance Report for the first time. To facilitate the production of a combined report, the Budget office took the lead in preparing the program performance section of the report in coordination with the Office of the Assistant Secretary for Public Affairs (ASPA) and the Office of Finance. These teams' adherence to the detailed milestone chart enabled us to meet the due date of February 1, 2003, for FY 2002 and will help us meet the February 1, and November 15, 2004, due dates for FY's 2003 and 2004, respectively.

Data Source: Transmittal memo and report from HHS to OMB.

Data Verification and Validation: The OMB verification of timely receipt of HHS submission.

Performance Progress: HHS met the target for FY 1999 and exceeded it for FY's 2000, 2001 and 2002.

Performance Goal 2. Clean Audit Opinion.

Establishing Performance Targets: The independent auditor's opinion determines whether the statements present fairly the financial condition of an entity while complying with generally accepted accounting principles (GAAP). If they do, an unqualified or "clean" opinion is rendered. If not, either a qualified opinion (one or more serious findings of deviations from accounting principles) or a disclaimer (not auditable) is given.

Discussion of FY 2002, FY 2003 and FY 2004 Targets: OMB has issued guidance which proposes to accelerate the schedule to require that the consolidated HHS statements and audit report be available at the time of the President's budget submission. The target due dates of February 1, 2003, for the FY 2002 report, February 1, 2004, for the FY 2003 report and

November 15, 2004, for the FY 2004 report, reflect that guidance. These dates will be adjusted if the guidance changes. Maintaining the clean opinion on HHS' consolidated statements may prove difficult as it is dependent on human resource skills and financial systems.

Data Source: Financial Statement Auditors Opinion and Date of the Opinion.

Data Verification and Validation: Copies of these reports are provided by the Inspector General and are kept on record.

Performance Progress: The audit opinion for the consolidated Departmental financial statements is based upon the audit opinions rendered for the individual OPDIV financial statements. HHS consistently has continued to improve the auditability of its financial statements. None of the statements prepared for the FY 1997 period were unqualified, but two HHS components received unqualified opinions for FY 1998, and HHS received its first clean opinion for the consolidated report for FY 1999. A second clean opinion was earned for FY 2000. Eight of the 9 HHS components' statements that support this goal, also received a clean opinion. For FY 2001, HHS received clean opinions for all ten HHS components' statements that supported the FY 2001 consolidated HHS reports. The FY 2002 consolidated report also received a clean opinion. At this point the major OPDIV's have earned clean opinions for FY 2002, and the remaining audited OPDIV's are expected to earn clean opinions.

Performance Goal 3. Unified Financial Management Systems

Establishing Performance Targets: HHS, like other Federal agencies, is moving forward in enhancing its electronic business (E-business) capabilities. A major drive in this effort is addressing satisfactorily the Department's leaders and managers' requirements for reliable, relevant and timely financial information upon which to make operational and strategic decisions. Also, the Department must be able to furnish its customers and service benefactors quality information regarding the Department's operational performance and its stewardship of financial resources entrusted to it.

One of the Department's objectives is to design and implement an integrated, automated financial management system that provides complete, consistent, reliable and timely financial information. This system must support the preparation of the HHS annual financial statements and other financial reports. In short, the system is being designed to integrate the Department's financial management systems network and fulfill the requirements stipulated in the Federal Financial Management Improvement Act of 1996 (FFMIA). The FFMIA requires each Federal agency to implement and maintain financial management systems that comply substantially with (1) Federal financial management systems requirements (promulgated primarily by OMB and the JFMIP); (2) applicable Federal accounting standards; and (3) the US Standard General Ledger (SGL) at the transaction level.

Currently, HHS operates five core accounting systems that do not satisfy adequately the FFMIA

requirements. Furthermore, the HHS components operate the systems on varying technological “platforms” at various locations. These systems utilize outdated technologies and are not readily capable of being modified to operate efficiently with modern integrated database systems. HHS is working to achieve a greater financial management economies of scale, eliminate duplicative systems and processes, and provide better service delivery by consolidating the existing systems into a unified system. This system – the Unified Financial Management System (UFMS) – when implemented fully, will provide uniform, integrated financial information for HHS management and decision-makers.

The Department is also consolidating accounting services and streamlining its financial infrastructure. Such consolidation and streamlining will enhance the Department’s ability to achieve greater operational efficiencies and at the same time deliver high quality, timely services to its customers and the American public.

Discussion of FY 2002, FY 2003 and FY 2004 targets: Consistent with the President’s Management Agenda under the improving financial performance initiative, the Department has instituted a “One HHS” approach to modernizing its financial systems. Related, this approach impacts all of HHS’ information technology by emphasizing management of resources on an enterprise-wide basis with a common technical infrastructure. In FY 2001, HHS initiated a six-year project to implement the UFMS and replace the existing five core accounting systems. The UFMS will consist of two major system sub-components. One sub-component, the Healthcare Integrated General Ledger and Accounting System (HIGLAS), will serve CMS and its Medicare contractors; the other sub-component will serve the remaining OPDIVs. Both sub-components will be integrated into a Department-wide financial reporting capability. This unified system will be designed to automate internal and external financial reporting requirements.

Data Source: Annual audit work and resulting opinions on the financial statements rendered by the Department’s auditor(s).

Data Verification and Validation: Data Verification and Validation are determined by the successful execution of project tasks to satisfy established milestones. The UFMS Program Management Office (PMO) is utilizing a third-party contractor to provide “arm’s length” IV&V support.

Performance Progress: As mentioned above, a high-level project plan was developed in FY 2001, and milestones were established for FYs 2002 and 2003. The PMO completed the planning phase during FY 2002. The Department brought a national firm on-board to perform systems integration activities. This firm and the PMO are working cooperatively to design and implement UFMS to fulfill Departmental objectives and pertinent requirements. The following have been accomplished as of the end of FY 2002:

Hired independent IV&V contractor	September 2001
Hired systems integrator	November 2001

DM GPRA Performance Plans

Hired UFMS Program Director	December 2001
Established UFMS PMO	January 2002
Developed Department-wide requirements for financial system	April 2002
Established executive governance structure	April 2002
Developed Department-wide Budget and Accounting Classification Structure (BACS)	April 2002
Developed UFMS Risk Assessment and Mitigation Plan	May 2002
Established "sandbox" UFMS testing capability	May 2002
Developed change management plan	June 2002
Developed organization and staffing plan	July 2002
Developed core financial system Target Business Model	July 2002
Developed performance measurement plan	July 2002
Began coordinating UFMS activities with Department-wide travel system activities; defined HHS-wide travel system requirements	August 2002
Finalized UFMS Implementation Plan and delivered to OMB	September 2002
Finalized UFMS Business Case and estimated return on investment calculations, for presentation to the HHS ITIRB	November 2002

Performance Goal 4. Electronic Funds Transfer (EFT)

Establishing Performance Targets: The goal expected for all payments is actually 100%. However, Treasury recognizes that there are barriers to achieving the 100% goal for vendor payments, so a "stretch" goal of 90% was established for vendor payments for FY 2002 even though HHS established an internal goal of 95%, which remains for FY 2003. The targets for grants and salary payments were deleted for FY 2002 since there is a three-year trend of substantial achievement of this goal and its targets. These rates will continue to be monitored internally.

Discussion of FY 2003 and FY 2004 Targets: The HHS targets will remain at 100% for travel, and 95% for vendor, payments. Currently, HHS vendor payments are at 92%, which meets the "stretch" goal established by Treasury but falls short of the 95% goal established by HHS.

Data Source: Quarterly EFT Reports and Treasury Guidelines of January 1999

Data Verification and Validation: Each OPDIV has an automated process for tabulating the number and types of payments made; this information is used to compile the quarterly statistics. The data is validated and verified via Treasury which tabulates the number and types of payments made based on the Agency Location Code(s) of an agency.

Performance Progress: HHS met or substantially met its FY 2002 targets except travel payments. However, actual performance for travel of 98% improved 2 above the FY 2001 level. Salary payments of 99% remain 1% below the 100% target.

Performance Goal 5. Timely Vendor Payments

Establishing Performance Targets: Timely payment by HHS of bills owed to vendors will avoid late fees and interest penalties as mandated under the Prompt Pay Act. They also indicate sound business practices.

Discussion of FY 2003 and FY 2004 Targets: The FY 2003 and FY 2004 targets are set at 97%. These targets are expected to be met since HHS' actual percentage was 98.3% for FY 2002 and 97.7% for FY 2001. HHS will work to continue improving its on-time percentage of vendor payments. New financial systems are in the planning stage, and it is possible they may impact the targets and accomplishments; however, no projections can be made at this time.

Data Source: Quarterly HHS Component Prompt Pay reports

Data Verification and Validation: OPDIV's verify by different methods.

Performance Progress: HHS's rates of on-time payments have increased from 91% for FY 1998 to 98.3% for FY 2002.

Performance Goal 6. Collection of Debts

Establishing Performance Targets: The 10% target is the increase in dollars collected over the prior fiscal year for debts owed to HHS.

Discussion of FY 2003 and 2004 Targets: The FY 2003 target of \$15.8 billion is 10% above the \$14.4 billion collected in FY 2002. The FY 2004 target will remain 10% above the dollars collected for the prior year. The measure was clarified from that in the FY 2001 plan to be clearer and consistent with the Accountability Report.

Data Source: Treasury Report on Receivables (formerly Schedule 9s).

Data Verification and Validation: The HHS Chief Financial Officer or Deputy Chief Financial Officer certifies annually that the amounts reported on the receivables report are correct and will be used to monitor compliance with the Debt Collection Improvement Act. The Chief Financial Officer verifies that the report has been reconciled to the HHS audited financial statements and submits this verification by March 31.

Performance Progress: In FY 2002 the \$14.4 billion in collections equals the collections in FY 2001, while total receivables decreased by \$200 million. As a percent of total receivables, FY 2002 collections were 51.8% which approximates the 51.6% collection rate for FY 2001.

Performance Goal 7. Improve the Average Time for Resolving Audits

Establishing Performance Targets: A reduction of 3% through FY 2003, and a reduction of 2.5% for FY 2004, in the average time in days required to resolve an audit under the Single Audit Act.

Discussion of FY 2003 and FY 2004 Targets: The average time (days) required for resolving audits in FY 2002 was 146.4 due to an unanticipated increase in the number of audits received (approximately 25% more than FY 2001). The Office of Audit Resolution and Cost Policy (OARCP) has revised its FY 2003 goal to be the previously-established FY 2002 goal of 132.9 assuming the number of new audits levels off. The target for FY 2004 has been reduced to a 2.5% decrease from FY 2003 as OARCP expects that the decrease in resolution time may flatten out gradually starting with FY 2004.

Date Source: DAR Management Information System

Data Verification and Validation: Office Director reviews and approves the system's input and analysis by the senior audit resolution staff.

Performance Progress: While the large and expected increase in new audit reports contributed to a setback in FY 2002, the average time for resolving audits under the Single Audit Act still had improved from 151 days in FY 1998 to 146.4 days in FY 2002.

Information Resources Management

Performance Goals	FY Targets	Actual Performance	Reference
Goal 1. Major systems development/major modification efforts demonstrate a high probability of success.			
Implement the Departmental Information Technology Review Board process to assure soundness of IT capital investments and to initiate appropriate corrective actions on major efforts as needed.			
1.1. 100% of IT investments approved by the ITIRB meet review criteria (i.e., OMB Memorandum M-97-02).	FY04: 100% FY03: 100% FY02: 100% FY01: 100% FY00: 100%	FY04: FY03: FY02: Met 100% FY01: Met 100% FY00: Met 100%	
1.2. 100% of IT investments considered but not approved by the ITIRB are subject to	FY04: FY03: 100% FY02: 100%	FY04: FY03: FY02: Met 100%	

DM GPRA Performance Plans

Performance Goals	FY Targets	Actual Performance	Reference
appropriate corrective actions and funding restrictions or terminations.	FY01: 100% FY00: 100%	FY01: Met 100% FY00: Met 100%	
Establish Operating Agency-Level Information Technology Architectures (ITA) within a Departmental ITA for use in evaluating IT investments.	FY04: FY03: 100% FY02: 100% FY01: 100% FY00: 100%	FY04: FY03: FY02: Met 100% FY01: Met 100% FY00: Met 100%	
1.3. 100% of IT investments approved by ITIRB meet review criteria (i.e., OMB Memorandum M-97-02).			
Initiate Enterprise Infrastructure Management to provide software distribution; asset, problem, and facilities management.	FY03: N/A FY02: N/A FY01: 50%	FY03: FY02: N/A FY01: Not met 20% FY00: 10%	
1.4. 100% of all COTS software (Tivoli) needed to distribute software is purchased and distributed, phased in over three years.			
1.5. 100% of all COTS software (Peregrine) needed to provide asset, problem and facilities management is purchased and distributed, phased in over three years.	FY03: N/A FY02: N/A FY01: 70%	FY03: FY02: N/A FY01: Met 80% FY00: 60%	
Initiate Enterprise Software Licenses to consolidate duplicative efforts.	FY04: FY03: 100% FY02: 100% FY01: 70%	FY04: FY03: FY02: Met 100% FY01: Met 80%	
1.6. 100% of all SAS software products are purchased from the Enterprise License to achieve a 20% purchase savings.			
Consolidate and Protect Department's IT Infrastructure.	FY04: FY03: Reduce number of servers throughout HHS by 25%; and complete consolidation of circuits throughout 10 regional offices. FY02: Reduce number of servers throughout HHS by 10% and consolidate circuits among 5 regional offices. FY01: Establish 5 year plan.	FY03: FY02: Ongoing FY01: Completed	
1.7. Establish and Implement a consolidated IT Strategic 5-Year Plan that supports "One HHS"	FY04: Complete software inventory FY03: Initiate software		

DM GPRA Performance Plans

Performance Goals	FY Targets	Actual Performance	Reference
1.8. Inventory IT Assets 1.9. Because of the clearer vision resulting from activities of Secretary Thompson's Five Year IT Strategic Plan, this performance goal has been changed from "Enhance the security of HHS internal network" to the following more meaningful goal: Improve reliability of critical IT infrastructure services.	inventory FY02: Initiate inventory of IT assets and complete 35%. FY03: Reduce successful intrusions by an additional 25%. NOTE: This target, developed in FY01, has been superceded by a more informative set of targets. FY02: Reduce successful intrusions by 25%. NOTE: This target, developed in FY01, has been superceded by a more informative set of targets. Updated Targets: FY04: Achieve 99.4% reliability of critical IT infrastructure services. FY04: Achieve 99.4% prevention effectiveness rate for potential security exploits, e.g. virus introductions, hacking, intrusions, defacements. FY03: Achieve 99.2% reliability of critical IT infrastructure services. FY03: Achieve a 99.2% prevention effectiveness rate for potential security exploits, e.g. virus introductions, hacking, intrusions, defacements. FY02: Achieve 99.0% reliability of critical IT infrastructure services. FY02: Achieve 99.0% prevention effectiveness rate for potential security exploits, e.g. virus introductions, hacking, intrusions, defacements. FY03: 99.7%	FY03: FY02: 100% (hardware) FY03: N/A FY02: N/A FY04: FY04: FY03: FY03: FY02: Met 99.93% FY02: Met 99.99%	

DM GPRA Performance Plans

Performance Goals	FY Targets	Actual Performance	Reference
1.10. Maintain the reliability of HHS IT systems.	FY02: 99.7%	FY03: FY02: Met 98%	
Goal 2. Departmental collections of information meet the requirements of the Paperwork Reduction Act of 1995.			
Eliminate illegal/bootleg collections of information.	FY04: 99% FY03: 99% FY02: 99%	FY04: FY03: FY02: Met 99%	
2.1. 99% of Departmental information collections have current OMB approval.	FY01: 99% FY00: 98% FY99: 97% FY98: 90%	FY01: Met 99% FY00: Met 99% FY99: Met 99% FY98: Met 90%	
Reduce, minimize and control burden placed on the public by Departmental information collections.	FY04: 5% of FY03 FY03: 5% of FY02 FY02: 5% of FY01 FY01: 5% of FY00	FY02: Not met (+19.3%) FY01: Not met (+3.5%)	
2.2. Achieve a 5% reduction in burden hours from the previous year.			
Monitor Department's implementation of GPEA.			
2.3. Information collections reviewed by the Department are in compliance with the requirements of GPEA.	FY04: 100% FY03: 89% FY02: 90%	FY03: 11/1/03 FY02: Met 90%	

Goal 1. Major systems development/major modification efforts demonstrate a high probability of success.

Performance Objective: Implement the Departmental Information Technology Review Board process to assure soundness of IT capital investments and to initiate appropriate corrective actions on major efforts as needed.

Measure 1.1: 100% of IT investments approved by the ITIRB meet review criteria (i.e., OMB Memorandum M-97-02).

Measure 1.2: 100% of IT investments considered but not approved by the ITIRB are subject to appropriate corrective actions and funding restrictions or terminations.

Establishing Performance Targets: Three meetings were held in FY 2001 to review three systems: EIM Business Case (approved December 2000); CIT's Procurement Contract Vehicle from CDC (approved May 2001) to continue and be expanded from Department-wide use;

CMS's integrated General Ledger Accounting System (HIGLAS) CMS has been working with the Department since January 2001 to improve their documentation in preparation for an ITIRB). The Department has held several business case reviews (January, March, April) of the HIGLAS ITIRB documentation still under development, to assist and guide the HIGLAS program to a successful ITIRB review. The Board has expanded its purview into any and all cross-cutting IT initiatives, including procurement vehicles that can have Department-wide use.

Note: OIRM is in the process of evaluating the efficacy of the structure of the current targets. An oversight role involving reviews of OPDIV-level performance may provide more insight into ITIRB processes and results than the current meeting-oriented measure.

Performance Objective: Establish OPDIV-level Enterprise Architectures (EA), formerly referred to as Information Technology Architecture (ITA) within a Departmental EA for use in evaluating IT investments.

Measure 1.3: 100% of IT investments approved by the ITIRB meet review criteria (i.e., OMB Memorandum M-97-02).

Establishing Performance Targets: In 1998, ASMB determined that HHS and the OPDIVs needed information technology architectures (ITA). In 1999 an ASMB/FDA-led task force began work on developing ITAs for the Department and each of the OPDIVs. The first two phases of this work have been completed and are used to gauge the investments brought before the Board.

Performance Report: All of the investments either met the requirements of the ITA or were brought into alignment through Board actions.

Performance Objective: Initiate Enterprise Infrastructure Management to provide software distribution; asset, problem, and facilities management.

Measure 1.4: 100% of all COTS software (Tivoli) needed to distribute software is purchased and distributed, phased in over three years.

Establishing Performance Targets: In 1999, ASMB determined that HHS and the OPDIVs needed an Enterprise Information Management to establish and conform to the Clinger-Cohen Act that establishes not only an IT review board for technology expenditure assessments against the Strategic Plan, but also established conformance to a mandated architecture. As part of that architecture strategy, the Enterprise Infrastructure Management (EIM) program requires standardized products, distribution and monitoring to assess and control expenditure, data exchange and provides Department-wide standards. Tivoli was one of the products chosen, via the results of the EIM Business Case analysis and Information Technology Investment Review Board (ITIRB), that met the Department's conformity mandates. We are reexamining the utility and necessity of the Tivoli product due to Peregrine's advances, therefore, we are not including

performance targets for FY02 and FY03.

Performance Report: All of the investments met the requirements of EIM.

Measure 1.5: 100% of all COTS software (Peregrine) needed to provide asset, problem and facilities management is purchased and distributed, phased in over three years.

Establishing Performance Targets: In 1999, ASMB determined that HHS and the OPDIVs needed an EIM to establish and conform to the Clinger-Cohen Act that establishes not only an IT review board for technology expenditure assessments against the Strategic Plan, but also established conformance to a mandated architecture. As part of that architecture strategy, the EIM program required standardized products, distribution and monitoring to assess and control expenditure, data exchange and provide Department-wide standards. Peregrine was one of the products chosen, via the results of the EIM Business Case analysis and ITRB, that met the Department's conformity mandates. We are reexamining the utility and necessity of the Tivoli product due to Peregrine advances, therefore, we are not including performance targets for either product at this time.

Performance Report: All of the investments met the requirements of EIM.

Performance Objective: Initiate Enterprise Software Licenses to consolidate duplicative efforts.

Measure 1.6: 100% of all SAS software products are purchased from the Enterprise License to achieve a 20% purchase savings.

Establishing Performance Targets: In 1999, ASMB determined that HHS and the OPDIVs needed an Enterprise Software Licensing effort as part of the Department's conformance to the Clinger-Cohen Act. Eliminating duplicative contract administrative efforts and achieving corporate purchasing power, these consolidated efforts provided benefits to the Department in cost savings and unlimited seat licensing for all OPDIV's. This effort also contributed to the requirement to manage technology expenditures per the Strategic Plan. As part of the architecture strategy, the EIM program required standardized products, distribution and monitoring to assess and control expenditures, data exchange and provided HHS-wide standards.

Performance Report: All of the investments met the requirements of EIM.

Performance Objective: Consolidate and protect Department's Information Technology Infrastructure.

Measure 1.7: Establish and implement a consolidated IT 5-year Strategic Plan that supports "One HHS."

FY01 Target: Establish and implement an IT 5 Year Strategic Plan.

Establishing Performance Targets: The Department established the target of an Information Technology (IT) Five Year Strategic Plan based on the Clinger-Cohen requirements to establish an enterprise-wide architecture. In order to accomplish this, and to achieve the Secretary's goal of "One HHS," the IT Five Year Strategic Plan focuses the resource requirements as well as expenditures on the prioritized objectives and projects of the Department.

Performance Report: The strategic plan will be monitored and updated as needed, but at least annually.

FY02 Target: Reduce number of servers throughout HHS by 10%; and consolidate circuits among 5 regional offices.

Establishing Performance Targets: Reducing the number of servers throughout the Department by 10% and consolidating circuits among 5 regional offices in FY02 begins to centralize the physical IT infrastructure into One HHS through consolidation.

Performance Report: Asset Center, a Peregrine application, will provide IT asset inventory reports that can be monitored for the progress of consolidation. (Note: The September 11, 2001 incident initiated a tremendous need for counter-terrorism application development, thus hindering the efforts to reduce overall server counts.)

FY03 Target: Reduce the number of servers throughout HHS by 25% and complete consolidation of circuits throughout 10 regional offices.

Establishing Performance Targets: Reducing the number of servers throughout the Department by 25% and consolidating circuits among the ten regional offices in FY03 continues to centralize the physical IT infrastructure into One HHS through consolidation.

Performance Report: Asset Center, a Peregrine application, will provide IT asset inventory reports that can be monitored for the progress of consolidation.

Measure 1.8: Inventory IT Assets.

FY02 Target: Initiate inventory of IT assets via the installation and implementation of Peregrine's Asset Center application and complete 35% of the inventory for FY02.

Establishing Performance Targets: The Department established a 35% completion for FY02 since funds are not available to continue distribution and installation of the Peregrine Asset Center application. However, a Secretary mandate to accomplish 100% hardware asset inventory was initiated and completed across the Department.

Performance Report: The automated IT hardware asset inventory was completed on December 5, 2001.

FY03 Target: Complete inventory Department-wide.

Establishing Performance Targets: The Department will complete the inventory of IT assets in FY03, providing funds are available to continue distribution and installation.

Performance Report: Asset Center, a Peregrine application, will provide IT asset inventory reports that can be monitored for the progress of consolidation.

Measure 1.9: The title of this measure has been changed from "Enhance the security of the HHS internal network" to the more applicable title "Improve reliability of critical IT infrastructure services." The targets, establishing performance targets and the performance report related to the "old" measure, remain below in bold but have been replaced with the new related targets, establishing performance targets and the performance report that follow this bolding.

FY02 Target: Reduce the successful intrusions by 25%.

Establishing Performance Targets: The Department has established the target of a reduction by 25% of successful intrusions for FY02. This will be accomplished by distribution and implementation of Tivoli's Policy Director, Risk Manager, and Intrusion Detection applications.

Performance Report: These three Tivoli applications cumulatively will produce security reports that delineate intrusion attempts to routers, firewalls and web servers while providing the identity of the IP address, the physical, geographic location of the intruder and restricts access to certain network resources.

FY03 Target: Reduce the successful intrusions by an additional 25%.

Establishing Performance Targets: We will continue to reduce successful intrusions by an additional 25% in FY03 as Tivoli's Policy Director, Risk Manager, and Intrusion Detection applications are rolled out to the remaining Agencies.

Performance Report: These three Tivoli applications cumulatively will produce security reports that delineate intrusion attempts to routers, firewalls and web servers while providing the identity of the IP address, the physical, geographic location of the intruder and restricts access to certain network resources.

The Department initiated its IT Security Program at the beginning of FY 2002, as part of the Secretary's Five-Year IT Strategic Plan. This effort has resulted in a reevaluation of the earlier and less effective approach to security improvement in favor of the more robust and full featured approach characterized by all the IT initiatives within Secretary Thompson's "One HHS" approach. The HHS IT Security Program is characterized by a function-oriented, rather than product-specific, approach to IT security enhancement. As a result, the Department has a

progressively and rapidly maturing security infrastructure and program based on 24/7 Department-wide security procedures, to name a few improvements. The HHS IT Security Program is founded on the goal of continuously pursuing a goal of unbreached availability, integrity, and confidentiality of HHS IT systems and data resources.

FY04 Target: Achieve 99.4% reliability of critical IT infrastructure services and a 99.4% prevention effectiveness rate for potential security exploits, e.g. virus introductions, hacking, intrusions, defacements.

Establishing Performance Targets: During FY04 the Department's Computer Security Incident Response Capability (CSIRC) and managed security services will be enhanced to make use of government-wide information resources that will contribute to an aggressive security incident prevention capability.

Performance Report: Data gathered by the Department's managed security service and CSIRC will be used in the production of the performance report.

FY02 Target: Achieve 99.0% reliability of critical IT infrastructure services and a 99.2% prevention effectiveness rate for potential security exploits, e.g. virus introductions, hacking, intrusions, defacements.

Establishing Performance Targets: During FY02 the Department embarked upon its Five Year Security Program and established four-tier virus protection across HHS. The entire HHS perimeter was reviewed for weaknesses and a Department-wide risk assessment performed. Findings from these efforts were applied productively in a manner that has resulted in more effective IT security incident prevention and response activities.

Performance Report: Data gathered by the Department's managed security service and CSIRC will be used in the production of the performance report.

Measure 1.10: Maintain the reliability of HHS IT systems.

FY02 Target: The Department established a target success rate of 99.7% for FY02 because anything less would be unacceptable.

Establishing Performance Targets: During FY02, the Uninterrupted Power Source (UPS) system was installed to ensure uninterrupted power during emergency and natural disasters. Backup and disaster recovery procedures were implemented across the Department.

Performance Report: Power availability can be measured via machine utilization reports and reporting instruction via the backup and recovery procedures.

FY03 Target: The Department established a target success rate of 99.7% for FY03 because

anything less would be unacceptable.

Establishing Performance Targets: During FY03, the UPS system will be maintained to ensure uninterrupted power during emergency and natural disasters. Backup and disaster recover procedures will be monitored across the Department.

Performance Report: Power availability can be measured via machine utilization reports, server uptime and reporting instruction via the backup and recovery procedures.

Goal 2. Departmental collections of information meet the requirements of the Paperwork Reduction Act of 1995

Performance Objective: Eliminate illegal/bootleg collections of information.

Measure 2.1: 99% of Departmental information collections have current OMB approval in FY 2000.

Establishing Performance Targets: The Paperwork Reduction Act requires that collections of information from the public receive prior approval from OMB. Accordingly in FY 1997, the Department set a goal of having at least 99% of information collections in compliance by FY 2000 and maintaining this level in the out years. A goal of 100% would not be realistic because new and revised collections are always under development.

Performance Report: As of the end of FY 1999, 99% of Departmental collections had current OMB approval number.

Performance Objective: Reduce, minimize and control burdens placed on the public by Departmental information collections.

Measure 2.2: Achieve a 5% reduction in burden hours from the base of the previous year, not including any new requirements until the following year.

Establishing Performance Targets: The existence of new legislative requirements, especially with respect to bio-terrorism, anthrax and other Homeland security issues has caused the Department to significantly increase information requirements. The Department will continue to monitor these requirements to ensure that only necessary additional burden is added.

Performance Objective: Monitor Departments Implementation of GPEA.

Measure 2.3: Information collections reviewed by the Department are in compliance with the requirements of GPEA.

FY02 Target: The Department established a target success rate of 90% for FY 2002 because

anything less would be unacceptable.

Establishing Performance Targets: During FY 2002 the Department expects that some out of compliance will still occur due to the need for PKI to be established to allow electronic signatures to accommodate the public need.

Performance Report: The Department has a comprehensive report that shows by Agency course of action that the Agency plans to get the collections into conformance. The Department will monitor that report and update it to track each Agency's progress towards accomplishing their cited goals.

FY03 Target: The Department established a target success rate of 89% for FY 2003.

Establishing Performance Targets: During FY03 the Department expects that PKI will be established to allow electronic signatures to accommodate the public need.

Performance Report: The Department continues to monitor each Agency's action plan to track each Agency's progress towards accomplishing their cited goals.

ASSISTANT SECRETARY FOR ADMINISTRATION AND MANAGEMENT

FY 2004 PERFORMANCE PLAN

Human Resources Services

Performance Goals	FY Targets	Actual Performance	Reference
Goal 1: Provide strategic leadership for managing human capital.			
Measure 1.3 - Complete one major program costs benefit analysis.	FY99: One	FY02: Drop Goal FY99: Not achieved	*See comment below
Measure 1.7 - OPDIVS have HR staff Proficient in workforce planning; all OPDIVs have functioning workforce planning system. Complete development of workforce planning capacity and integration with budget and Results Act cycles.	FY02: 100% of OPDIVs FY01: 60% FY00: 30% FY99: all OPDIVs	FY02: Goal completed FY01: Achieved FY00: 33% FY99: Partially achieved. Agency submissions for 2001 to budget review board showed some continued weaknesses.	
Measure 1.8 - OHR web site is expanded to include content for additional functional area coverage.	FY03: Not applicable FY02: Web pages are developed for 3 additional functional areas.	FY03: Goal completed FY02: Achieved	
Measure 1.9 - Develop a department-wide recruitment and retention strategy that addresses skill needs identified through formal workforce planning processes.	FY03: Ongoing implementation results in right skills in mission-critical occupations. FY02: Strategy is developed and deployed.	FY04: FY03: FY02:	*See comment below
Measure 1.10 - Restructure the Department's personnel service delivery function.	FY03: Reduce the number of personnel offices to 4 FY02: Reduce the number of HHS Personnel offices from 40 to 6 through consolidation of HR offices in FDA and NIH.	FY04: FY03: FY02:	

Goal 2: Improve the quality of worklife for HHS employees. Measure 2.1 - Secretary's and OPDIV annual reports, supplemented by the results of the annual survey of employees, show improvement in QWL indicators. Measure 2.3 - Pro-active labor relations program demonstrates positive impact on organizational performance. Measure 2.8 - Hispanic/Latino representation improves by 2.0% by end of FY 2004.	FY03: Significant improvement FY02: Significant improvement FY01: Significant improvement FY00: Significant improvement FY03: Third party activity reduced 15%. E.O. 13203 implemented at 85% of bargaining units. FY02: Third party activity remains static. E.O. 13202 implements at all OPDIVs and 50% of bargaining units. FY04: 5.1% FY03: 4.6% FY02: 4.1% FY01: 3.6% [Baseline is 3.1%, the status as of 9/30/0]	FY03: Drop Goal FY02: Achieved FY01: Achieved FY00: Achieved FY03: Drop Goal FY02: FY04: FY03: FY02: FY01: 3.3%	
--	---	---	--

Narrative Comments:

The Office of Human Resources's (OHR) overall objective is to support HHS program mission accomplishment through the planned and efficient use of human capital.

Some of the activities of OHR are not readily susceptible to measurement. These include decision-support for the Assistant Secretary for Administration and Management and the Secretary; liaison with central management agencies; participation in interagency activities, and *ad hoc* technical assistance.

Note that goals and performance measures noted as completed or being dropped in earlier reports have been removed from this document. Goals and measures that have been completed in FY02 or are superseded are noted as such in this plan and will be dropped from future reports.

Notes on Specific Performance Goals and Results:

Measure 1.3: This measure is being dropped since it does not accord with OHR functional priorities.

Measure 1.10: Targets have been adjusted to reflect agreements with OMB and HR restructuring.

Measure 2.3: This measure is being dropped since the target measures activity rather than organizational results.

Facilities Management Group

Performance Goals	FY Targets	Actual Performance	Reference
Goal 1: Provide a safe and healthy work environment for HHS employees and visitors. Measure 1: Percentage of HHS organizations evaluated which exceeded the Federal government's average workers compensation total claims rate the previous year. Measure 2: Number of security awareness notices distributed to HHH Building occupants.	FY04: 50% FY03: 50% FY02: 50% FY01: 50% FY00: 50% (New) FY03: Drop Goal FY02: 10 FY01: 8 FY00: 6 (New)	FY02: FY01: 100% FY00: 50% FY02: FY01: 19 FY00: 15	
Goal 2: Ensure that requests for building services in the HHH Building are acknowledged on the day received and corrective action taken within 72 hours. Measure: Number of complaints addressed within 72 hours as a percentage of the total number of requests received.	FY04: 100% FY03: 100% FY02: 100% FY01: 100% FY00: 100% FY99: 95%	FY02: FY01: 100% FY00: 100% FY99: 100%	

The Facilities Management Group (FMG) supports and advises all HHS organizational components in the SW Complex (Humphrey, Cohen, and Switzer Buildings) and downtown Washington DC business district on issues of space design, construction and utilization, handicapped accessibility and rent management. It is also responsible for facilities management services in the Hubert H. Humphrey Building including operations and maintenance, facilities-related service calls, cyclical painting, cleaning, conference room maintenance, set-up and assignment, facilities coordination for special events, construction and Continuity of Operations (COOP) for the HHS portion of the Washington DC, Southwest complex. FMG also provides liaison services with the General Services Administration for all HHS components in the SW complex. FMG's strategic goals are to ensure that HHS real property assets are protected and utilized effectively; and that HHS employees and visitors have access to a healthy and safe work environment.

Performance Report Summary**Goal 1. Provide a safe and healthy work environment for HHS employees and visitors.**

Measure 1: Percentage of HHS organizations evaluated which exceeded the Federal government's average total workers compensation claims rate the previous year. FY 2001 Target: 50%.

Establishing Performance Targets: In concert with the President's Federal Worker 2000 Initiative, this performance measure and target focuses on those HHS facilities which exceeded the Federal government's average total compensation claims rate the previous fiscal year. In evaluating these organizations, limited resources are better utilized in those areas which have the greatest problems and the most room for improvement. The successful accomplishment of this goal will provide HHS employees with a safer, healthier work environment, control compensation costs, and improve productivity.

Performance Report: Only one HHS organization, the Indian Health Service (IHS), was found to exceed the Federal government's average total claims rate for FY 2000. An evaluation of the IHS Occupational Safety and Health Program was initiated during FY 2001 using the Federal Worker 2000 Action Plan as a guide. Because of the sudden retirement of the Department's Occupational Safety and Health Officer who performed this function, and inability to hire a replacement, the start of this evaluation was delayed. The review will be completed in early 2002.

Measure 2: Issue security awareness notices to HHH Building occupants. FY 2002 Target: 10.

Establishing Performance Targets: The performance target is based on historical knowledge and assessment of the number of times throughout the year when employees would benefit from security awareness notices. This measure is being dropped for future years since the target measures activity rather than organizational results.

Performance Report: In FY 2001, FS issued 19 informational notices to HHS Building occupants. Topics included the prevention of office theft, shopping smart, tips to avoid summer weather hazards, information concerning special building admittance and security procedures during a presidential visit and during Inauguration Day, and information concerning fire alarm procedures and evacuations.

Goal 2. Ensure that requests for building services in the HHH Building are acknowledged on the day received and corrective action taken within 72 hours.

Measure: Number of complaints addressed within 72 hours as a percentage of the total number of requests received. FY 2001 Target: 100%.

Establishing Performance Targets: The performance target is based on GSA guidelines that building services complaints be addressed within 72 hours of receipt.

Performance Report: The FY 2001 and FY 2000 performance targets were achieved. FMG current practices and procedures adhere to the GSA guidelines that building services complaints be responded to within 72 hours of receipt. To verify performance in this area, an independent analysis of computer generated data from the FMG service call system is performed. In order to ensure the accuracy of this data, a manual, random, periodic review of an individual work orders issued as a result of a request for service is pulled and performance verified. This has consistently supported the automated reports.

Office of Grants and Acquisition Management

Performance Goals	FY Targets	Actual Performance	Reference
Goal 1. Increase the effectiveness of HHS Grants, Procurement, and Logistics Policies using periodic customer feedback.	FY04: 4.0 of 5 FY03: * FY02: * FY01: 3.9 of 5 FY00: * FY99: * *Effectiveness is measured every third year. FY01 will be measured in FY02.	FY04: FY03: FY02: FY01: 03/01/03 FY00: * FY99: * FY98: Baseline 3.4	
Goal 2. Increase the effectiveness of HHS Grants, Procurement, and Logistics Training, using periodic customer feedback.	FY04: 4.0 of 5 FY03: * FY02: * FY01: 3.9 of 5 FY00: * FY99: * *Effectiveness is measured every third year. FY01 will be measured in FY02.	FY04: FY03: FY02: FY01: 03/01/03 FY00: * FY99: * FY98: Baseline 3.4	

DM GPRA Performance Plans

Goal 3. Achieve 100% of the SBA Negotiated goal categories:		
3.1. Small Business	FY04: (*) FY03: 30% (\$1.4B) FY02: 30% (\$1.4B) FY01: 32% (\$1.4B) FY00: 32% (\$1.4B) FY99: 32% (\$1.4B)	FY04: FY03: FY02: FY01: 31.7% (\$1.5B) FY00: 26.05% (\$1.1B) FY99: 27.3% (\$1.3B)
3.2. (A) Awards	FY04: (*) FY03: 4.1% (\$193M) FY02: 3.9% (\$181M) FY01: 4.3% (\$200M) FY00: 4.3% (\$225M) FY99: 4.8% (\$223M)	FY04: FY03: FY02: FY01: 4.6% (\$222M) FY00: 3.3% (\$145M) FY99: 4.4% (\$221M)
3.3. SDB Awards (Small Disadvantaged Business Awards)	FY04: (*) FY03: 7.6% (\$353M) FY02: 7.3% (\$339M) FY01: 9.6% (\$440M) FY00: 9.6% (\$440M) FY99: 10.4% (\$479M)	FY04: FY03: FY02: FY01: 10.33% (\$500M) FY00: 7.2% (\$316M) FY99: 9.0% (\$345M)
3.4. WOSB Awards (Women-owned small business)	FY04: (*) FY03: 5% (\$235M) FY02: 5% (\$233M) FY01: 14%** (\$649M) FY00: 14% (\$164M) FY99: 4.6% (\$210M) **This is an administrative error as the Governmentwide goal for Women-Owned Business is 5%. This will be adjusted in FY02.	FY04: FY03: FY02: FY01: 5.5% (\$264M) FY00: 3.9% (\$170M) FY99: 3.3% (\$166M)
3.5. HUBZONE Awards	FY04: (*) FY03: 3% (\$141M) FY02: 2.5% (\$116M) FY01: 2.0% (\$92M) FY00: 1.5% (\$67M)	FY04: FY03: FY02: FY01: .6% (\$29M) FY00: .14% (\$6M)
3.6 SDVOSB Awards (Service - Disabled Veterans Owned Small Business)	FY04: (*) FY03: 3% (\$140M) FY02: 3% (\$140M) FY01: 1.5% (\$69M) (*) goals are negotiated for each preceding year with the SBA. Fluctuating Federal budgets are the basis for not	FY04: FY03: FY02: FY01: 1% (\$44M) * Changes have been made in Performance numbers since 2002 submission because data input is a continual process.

DM GPRA Performance Plans

Goal 4. Improve Contract Operations.			
4.1 Customer Satisfaction	FY04: 89.1% FY03: n/a FY02: 87.4% FY01: n/a FY00: n/a	FY04: FY03: n/a FY02: tbd FY01: n/a FY00: 83.2% baseline*	
4.2 Employee Satisfaction	FY04: 77.2% FY03: n/a FY02: 75.7% FY01: n/a FY00: n/a	FY04: FY03: n/a FY02: tbd FY01: n/a FY00: 72.1% baseline*	
4.3 Vendor Satisfaction	FY04: 86.6% FY03: n/a FY02: 84.9% FY01: n/a FY00: n/a	FY04: FY03: n/a FY02: tbd FY01: n/a FY00: 80.9% baseline* * This baseline has been adjusted to reflect major system changes, and will be the starting point for future targets.	
Goal 5. Increase use of Performance Based Contracting	FY04: tbd by OMB FY03: 30% (tbd by OMB) FY02: 20%	FY04: FY03: FY02:	
Goal 6. Maximize use of FedBiz Opps.	FY04: 100% FY03: 100% FY02: 100%	FY04: FY03: FY02:	
Goal 7. Increase competition of Department's Fair Act Inventory.	FY04: tbd by OMB FY03: 10% (Cum 15%) FY02: 5%	FY04: FY03: FY02:	
Goal 8. Ensure HHS Grant Administrative Policies are current.	FY04: 100% FY03: 100% FY02: 100% FY01: 96% FY00: 93% FY99: 85%	FY04: FY03: FY02: FY01: 96% FY00: 93% FY99: 85% FY98: Baseline 75%	

DM GPRA Performance Plans

Goal 9. Implement the initial plan of Public Law 106-107, Federal Financial Assistance Management Improvement Act (new in FY 2003)	FY04: Consolidate and coordinate application and reporting forms and data elements, improve the quality and usefulness of grantee audits, and increase automation in all aspects of the grants process. FY03: Establish the baseline of application and reporting forms and data elements, review Federal audit processes, and identify agency automation capabilities.	FY04: FY03:	
Goal 10. Increase Location Accuracy of Capitalized Personal Property Records	FY04: 96% FY03: 96% FY02: 96% FY01: 96% FY00: 94% FY99: 92%	FY04: FY03: FY02: FY01: 97% FY00: 97% FY99: 97% FY98: Baseline 90%	
Goal 11. Increase Access to HHS Grants Administrative Policies	FY02: 100%* FY01: 100% FY00: 100% FY99: 80% *100% achieved for 3 consecutive years. Goal will be dropped after FY02.	FY02: * FY01: 100% FY00: 100% FY99: 100% FY98: Baseline 70%	
*Goal 12. Protect HHS assets by identifying and properly accounting for the Department's real property holdings. Measure 1: Hold OPDIV Foundation Information for Real Property Management (FIRM) database users group meetings to identify and resolve problems. Measure 2: Percentage of acquisitions and disposals executed in accordance with regulations.	FY04: 2 FY03: 2 FY02: 2 FY01: 2 (New) FY04: 100% FY03: 100% FY02: 100% FY01: 100% FY00: 100% FY99: 90%	FY04: FY03: FY02: FY01: 2+ FY04: FY03: FY02: FY01: 100% FY00: 100% FY99: 100%	

DM GPRA Performance Plans

*Goal 13. Reduce energy consumption at HHS facilities as mandated by the Energy Policy Act of 1992 (EP Act), E.O. 12902, and E.O. 13123. Measure: Number of buildings audited for energy usage as a percentage of the total number of buildings in the HHS inventory.	FY04: tbd by OMB FY03: 80% FY02: 70% FY01: 60% FY00: 50% FY99: 40%	FY04: FY03: FY02: 03/01/03 FY01: 55% FY00: 50% FY99: 48%	
*Goal 14. Provide a safe and healthful work environment for HHS employees and visitors. Measure 1: Percentage of HHS organizational evaluated which exceeded the Federal government's average workers compensation total claims rate the previous year. Measure 2: Number of security audits conducted of HHS-owned, leased and delegated buildings to monitor compliance with DOJ minimum level requirements.	FY04: 50% FY03: 50% FY02: Suspended FY01: 50% FY00: 50% (New) FY04: 2 FY03: 2 FY02: Suspended FY01: Suspended FY00: 2 FY99: 2	FY01: 100% FY00: 50% FY01: Suspended FY00: 2 FY99: 3	

*In FY 2002, the functions outlined in Goals 12, 13, and 14 were transferred to the Office of Grants and Acquisition Management. They previously resided in Facilities Services.

Goal 1: Increase the effectiveness of HHS Grants, Procurement, and Logistics Policies

Performance Goal: The Office of Grants and Acquisition Management (OGAM) is responsible for issuing Department-wide grants, procurement, and logistics policies. Policies are issued to improve stewardship of government assets such as grant and procurement funds and personal property, while reducing administrative burdens on HHS offices, grantees and contractors and while protecting the government's assets and maximizing efficiency and effectiveness. This goal measures the effectiveness of the policies in meeting these objectives.

Performance Measurement: Summary of Agency ratings of the effectiveness of policies on a scale of 0 to 5.

In FY 1998, to measure the effectiveness of its policies, OGAM developed a survey instrument

consisting of multiple questions in different areas, resulting in a composite score, to obtain opinions from the OPDIVs on the effectiveness of OGAM's policy functions. (The OPDIVs are responsible for surveying grantees and contractors.) The initial survey, conducted in FY 1998, established a baseline of 3.4 on scale of 0 to 5. The survey will be conducted every third year, resuming in FY 2002. Many new initiatives in legislation and management practices have occurred in FY 2000 and FY 2001. The survey has been postponed one year to evaluate OGAM leadership in these areas.

Results: Results will be available after the next survey is completed in FY 2002.

Goal 2: Increase the effectiveness of HHS Grants, Procurement and Logistics Training

Performance Goal: OGAM is responsible for providing Department-wide grants, procurement, and logistics training. A trained workforce is essential to assure that HHS and government-wide policies are implemented efficiently and effectively and to assure high productivity among the professional grants, procurement and logistics personnel in carrying out their stewardship role. This goal measures the effectiveness of the training in meeting these objectives.

Performance Measurement: Summary of Agency ratings of the effectiveness of training on a scale of 0 to 5.

In FY 1998, to measure the effectiveness of its training programs, OGAM developed and implemented a survey instrument consisting of multiple questions in different areas resulting in a composite score, to obtain opinions from the OPDIVs on the effectiveness of OGAM's training functions. (The OPDIVs are responsible for surveying grantees and contractors.) The initial survey, conducted in FY 1998, established a baseline of 3.4 on scale of 0 to 5. The survey will be conducted every third year, resuming in FY 2002. Many new initiatives in legislation and management practices have occurred in FY 2000 and FY 2001. The survey has been postponed one year to evaluate OGAM leadership in these areas.

Results: Results will be available after the next survey is completed in FY 2002.

Goal 3. Achieve 100% of the Small Business Administration (SBA) Negotiated Goal Categories

Performance Goal: Public Law 95-507, Section 221, and Public Law 100-656, Sections 502 and 503, require the head of each Federal agency, after consultation with the US Small Business Administration (SBA), to establish, on a bi-annual basis, realistic goals for the award of contracts to small business concerns and to small business concerns owned and controlled by socially and economically disadvantaged individuals.

Performance Measurement: Section 15(g)(1) of the Small Business Act requires the Federal government to establish a goal of awarding 23% of all prime contract dollars for small

businesses. Of the 23%, 5% should be awarded to socially and economically disadvantaged individuals and to women-owned businesses, respectively, 2.5% should be awarded to Historically Underutilized Business Zones (HUBZone) small businesses, and 3% should be awarded to Service-Disabled Veteran-Owned small business (SDVOSB).

In order for the Federal government to accomplish this goal, each Federal agency negotiates a weighted portion of the goal with the SBA. HHS' FY 2002 negotiated goals are 30% for small business awards, *3.9% for Section 8(a) awards, 7.3% for S.B., 5% for women-owned businesses, 2.5% for HUBZone and 3% for Service-Disabled Veteran Owned Small Business (SDVOSB). All goals are expressed in terms of numbers, dollars and percentages. If there is any variance from the projected base amount, the percentage goal is the controlling factor and will be used to measure actual attainment. Success is measured in terms of meeting or exceeding each Agency's negotiated percentages.

*The 8(a) goal is agency specific. In FY 2002, the 8(a) goal and the SDB goal have been combined for an 11.7% goal. 8(a) numbers are counted as part of the overall S.B. government-wide accomplishment.

For the first time, HHS exceeded the Federally mandated women owned business goal of 5% by achieving 5.5%.

Results: The Federal Government fell slightly short of its FY 2001 goal of 23%. However, HHS achieved 31.7% of a 32% small business goal in FY 2001.

Aggressive efforts are underway to unify our business process. The Department is also working to enhance its subcontracting program to ensure that small businesses receive opportunities on larger procurement efforts. Finally, HHS is working to implement measures that will increase opportunities for HUBZone as well as other soci-economic categories of small businesses.

Goal 4. Improve Contract Operations

Performance Goal: The Office of Acquisition Management's (OAM) goal is to improve contract operations throughout the Department.

Performance Measurement: Progress in achieving this goal is measured by using composite contract Operations rating based on survey results from HHS's Acquisition Balanced Scorecard. OAM has developed a results-driven Acquisition Balanced Scorecard to measure and improve acquisition performance throughout the Department. HHS's Acquisition Balanced Scorecard represents a new, cost-effective approach to performance management and oversight. The Scorecard strives to achieve balance among various perspectives and goals, such as efficient business processes, innovative leadership, empowered employees, satisfied customers, and dedicated vendors. HHS's Agencies compile performance data using pretested surveys of stakeholders, such as customers, contractors, and employees. Performance data is entered,

tracked and analyzed using a variety of software and web-based applications. Performance gaps are identified, and cross-functional teams are used to target opportunities for organizational improvement.

Results: In FY 2000, OAM: (a) conducted web-based surveys to compile current, accurate and meaningful performance data; (b) established a new, fair, and GPRA-complaint composite baseline based on a roll-up of that data; and (c) developed realistic acquisition performance targets to spur organizational improvements. Acquisition Balanced Scorecard surveys are conducted every two years. Thus, performance targets are aligned with that two-year cycle. Moreover, OAM put a methodology in place (i.e., a bench marking forum) to promote the sharing of performance results and improvements throughout the Department - - while avoiding any misleading or simplistic performance comparisons among HHS's contracting offices. (Please note that for subsequent GPRA submission, we plan to establish and incorporate appropriate internal goals and objectives to gauge our progress in implementing the Procurement Executive Council's "Government-wide Acquisition Performance Measurement Program".)

HHS is continuing to hold regular Acquisition Balanced Scorecard User Group meetings to promote high quality acquisition performance measurement performance management, and organizational improvement at each of our OPDIVs. In addition, the Department is conducting an acquisition efficiency study using statistical cost function and data envelopment analyses, to support optimum workload and workforce planning. Lastly, HHS plans to conduct a second Benchmarking Forum in FY 2003, to foster organizational improvement efforts across the Department. This benchmarking process will enable OAM to roll up its OPDIV survey results and gauge HHS's overall Scorecard performance against the stated GPRA goals.

Goal 5. Increase the use of Performance-Based Contracting

Performance Goal: The Department is committed to reaching the OMB and Procurement Executive Council goal of using performance-based contracting (PBC) to award 20% of eligible service contracting dollars by FY 2002. An additional 10% of eligible service contracting dollars will be targeted for FY 2003.

Performance Measurement: To meet this goal, the Secretary sent a letter to the OPDIV Heads stressing the need for program and contracting communities to work in partnership to aggressively apply PBC. We plan to continue to enhance our web-based PBC knowledge repository (www.ogam2000.com/acquisition/pbc.htm); to strengthen our hands-on PBC workshops; to reward and recognize PBC efforts; to target opportunities for improvement using our management information systems; and to continue to address this topic at conferences and meetings across the Department.

Results: HHS is on track to meet its FY 2002 goal of meeting 20% of eligible service contracting dollars. Moreover, the Department is playing an active role on OMB's inter-agency PBC team, which is dedicated to strengthening and streamlining PBC-related FAR rules, FPDS

guidance, and implementation for all Federal agencies.

Goal 6. Maximize use of FedBiz Opps (Federal Business Opportunities)

Performance Goal: All HHS Agencies are on track to use FedBiz Opps, a government-wide point of entry, to post 100% of synopses and applicable solicitations on-line, beginning October 1, 2001 (the statutory due date).

Performance Measurement: OGAM will comply with all laws and regulations in this area, and will continue to alert Agency contracting personnel to pertinent training opportunities. For example, OGAM addressed FedBiz Opps at the Department's May 8-9, 2001, acquisition and small business conference on performance-based government. In addition, OGAM has posted registration instructions and other important information regarding FedBiz Opps on our e-Business Supersite under KnowNet-HHS' award winning knowledge management system. This FedBiz Opps information may be found at www.ogam2000.com/ec/.

Results: HHS procurement offices have been posting 100% of all applicable procurement Synopses to FedBiz Opps, since October 1, 2001. During the period October 1, 2001-December 31, 2001, publication of the Commerce Business Daily continued in parallel with FedBiz Opps; however, the Commerce Business Daily ceased publication on January 1, 2002. FedBiz Opps is now the only avenue available for publishing procurement Synopses. This goal will be tracked through FY 2004. If performance remains at 100%, the goal will be dropped.

Goal 7. Increase Competition of the Department's FAIR Act Inventory.

Performance Goal: The goal of competing or directly outsourcing 10% of the inventory for FY 2003 has been officially put before the OPDIVs, and their plans for achieving the goal were approved by OMB.

Performance Measurement: ASAM received plans from all OPDIVs that meet the 10% goal of competitive sourcing for FY 2003. The OPDIVs will work towards that goal throughout the fiscal year.

Results: HHS achieved the FY 2002 goal by subjecting 5% of the FAIR Act inventory to competition or direct conversion in FY 2002. HHS is on schedule to subject 10% of the FAIR Act inventory to competition or direct conversion before the end of FY 2003.

Goal 8. Ensure that HHS Grant Administrative Policies are current.

Performance Goal: The Office of Grants Management's (OGM) goal is to ensure that HHS grant administrative policy issuances are current.

Performance Measurement: OGM is responsible for developing, issuing and implementing

grants administrative polices used by the various HHS awarding agencies in the award and administration of the three hundred-plus grant programs HHS administers. Grants polices, issued by the Department to ensure accountability of the grant funds, provide guidance to grants management staff and other HHS staff involved in the award and administration of grants. The performance measure is based on the percentage of policy issuances that have been reviewed and, as needed, updated at least once every four years.

Results: By the end of FY 2002, OGM had reviewed and, as needed, updated 96% of its grants policy issuances.

Goal 9. Implement the Initial Plan of PL 106-107, Federal Financial Assistance Management Improvement Act (new in FY 2003).

Performance Goal: The Federal Grant Streamlining Program is responsible for overseeing the government wide grant reform effort mandated by Public Law 106-107. HHS is the lead Federal agency for this activity, and OGAM is charged with implementation in the Department. The purposes of the Act are to: (1) improve the effectiveness and performance of Federal financial assistance programs, (2) simplify Federal financial assistance application and reporting requirements, (3) improve the delivery of services to the public, and (4) facilitate greater coordination among those responsible for delivering the services. Four work groups and an oversight team are working to implement the plan.

Performance Measurement: Establish baseline information in FY 2002 and FY 2003 of grant requirements. There are four external work groups: pre-award, post-award, audit oversight, and electronic processing which collectively address all aspects of Federal grant administration. For pre-award and post-award efforts, the focus is on consolidation and coordination among agencies to use the same or similar forms and data elements to apply for, administer, and report on grant activity. The audit team is addressing the quality, timeliness, and usefulness of audit information for grant managers. The aim of the electronic work group is to establish the Federal Commons, which will serve as the single point of entry for E-commerce over the entire grant life cycle, offering both general information exchange and secure electronic transaction processing. These activities will be mirrored within the Department.

Results: Results will be available early in FY 2004, since progress can be measured incrementally (on a quarterly basis) for all aspects of this effort.

Goal 10. Increase Location Accuracy of Capitalized Personal Property Records.

Performance Goal: The goal is to assure that adequate stewardship is exercised over the Department's investment in equipment. Equipment is essential to carry out the Department's scientific, regulatory, and administrative missions. The lack of adequate property stewardship can result in unnecessary expenditures of funds. Funds have to be used to replace lost items or to purchase duplicate items for equipment already in the inventory. Productivity is lost when

mission essential equipment is not available. Good stewardship over equipment assets also will increase the accuracy of Department's presentation of personal property assets in the annual financial statements required by the Chief Financial Officer Act and provide a better understanding of the resources required to carry out the Department's missions.

Performance Measurement: Progress toward this goal will be measured by determining a location accuracy percentage based on comparing the results of the annual physical inventory of capitalized equipment to the capitalized equipment inventory records. To calculate the percentage, the number of "not found items" and the number of "found but not recorded items" are subtracted from the number of capitalized items in the property records to determine the numerator, which is then divided by the number of capitalized items in the property records.

Results: The Agency's reported an average accuracy rate of 97%, exceeding the goal of 94%.

Goal 11. Increase Access to HHS Grants Administrative Policies.

Performance Goal: The Office of Grants Management's (OGM) goal is to increase access to HHS grants administrative policy issuances through use of the Internet.

Performance Measurement: Increasing access to Departmental grants administrative policies helps ensure that all HHS staffs responsible for grant programs have readily available to them the policy guidance necessary to administer grant programs. Using web-based services accessible to all Departmental staff involved in grants administration is an effective way of ensuring ready access to such guidance. Key to achieving this goal is the electronic posting of the Departmental grants administrative policy issuances.

To measure accomplishment of the goal, OGM will calculate the percentage of grants administrative policy issuances posted electronically under GrantsNet, the Department's online grants information service.

Results: 100% Actual Performance reached in three consecutive years. Goal will be dropped in FY 2002.

Goal 12. Protect HHS assets by identifying and properly accounting for the Department's real property holdings.

Performance Goal: Measure 1 - Increase the number of OPDIVs with on-line input to the Foundation Information for Real Property Management (FIRM) database. FY 2001 Target: 2.

Establishing Performance Targets: In 1997, the former Assistant Secretary for Management and Budget ASMB) determined that HHS needed a Department-wide automated system to manage and account for its real property assets in a uniform manner to meet the requirements of the Chief Financial Officers Act. The GSA FIRM system was acquired and implementation began

in FY 1998. The FY 2000 performance measure and target was to increase the number of OPDIVs with on-line input to the FIRM database to ten. Now that we have met the FY 2000 target, all major OPDIVs with real property holdings have on-line access to FIRM. Therefore, this performance measure was revised in FY 2001 and FY 2002 to reflect the technical support that ORP will provide to OPDIVs utilizing the FIRM system. The target of two FIRM users group meetings was established in consultation with OPDIV representatives on the work group.

Performance Report: The FY 2000 target of 10 OPDIVs with on-line access to the FIRM system has been met with the addition of ACF and HRSA. The FY 1999 target of 8 was met with the installation of FIRM and training of staff at AoA, CDC, FDA, CMS, IHS, NIH, the Office of the Secretary, and the Program Support Center.

Measure 2 - Percentage of acquisitions and disposals executed in accordance with regulations. FY 2001 Target: 100%.

Establishing Performance Targets: The target for acquisitions and disposals is based on Federal Real Property Regulations and HHS policy.

Performance Report: 100% of the real property acquisitions and disposals during FY 2001 were reviewed and properly executed. 100% of the 21 real property acquisitions, transfers and disposals reviewed during FY 2000 were properly executed. In FY 1999, 100% of the 18 real property acquisitions and disposals reviewed were properly executed.

Goal 13. Reduce energy consumption at HHS facilities as mandated by the Energy Policy Act of 1992, E.O. 12902, and E.O. 13123.

Measure - Number of buildings audited for energy usage as a percentage of the total number of buildings in the HHS inventory. FY 2001 Target: 60%

Establishing Performance Targets: In accordance with the Energy Policy Act of 1992 (EPA) and E.O. 12902, ORP developed a Department-wide energy program based on an energy compliance review of all HHS OPDIVs. This compliance review concentrated on the energy auditing requirements of EPA and E.O. 12902. The findings of the review highlighted specific areas of need in the OPDIVs. The performance targets are based on the OPDIVs' Ten-Year Energy Audit Plans.

Performance Report: E.O. 12902 directed Federal agencies to develop and implement a ten year plan to conduct comprehensive facility energy audits, ensuring that 10% of the agency's facilities are audited each year (beginning in FY 1996). By the end of FY 2000, HHS had completed energy audits on 50% of our facilities. By the end of FY 1999, HHS had completed energy audits on 48% of our facilities (8% above our target).

The purpose of an audit is to provide detailed information to identify and prioritize energy

conservation projects. The audits conducted on HHS facilities have served as the impetus for lighting retrofits, chiller upgrades, water conservation projects, as well as entering into energy savings performance contracts.

Goal 14. Provide a safe and healthful work environment for HHS employees and visitors.

Measure 1 - Percentage of HHS organizations evaluated which exceeded the Federal government's average total workers compensation claims rate the previous year. FY 2001 Target: 50%.

This goal is suspended for FY 2002 due to staff retirement.

Establishing Performance Targets: In concert with the President's Federal Worker 2000 Initiative, this performance measure and target focuses on those HHS facilities which exceeded the Federal government's average total compensation claims rate the previous fiscal year. In evaluating these organizations, limited resources are better utilized in those areas which have the greatest problems and the most room for improvement. The successful accomplishment of this goal will provide HHS employees with a safer, healthier work environment, control compensation costs, and improve productivity.

Performance Report: Actual performance of this goal was awaiting the completion of the HHS Federal Worker 2000 Action Plan. Only one HHS organization, the Indian Health Service (IHS), exceeded the Federal government's average total claims rate for FY 1999. IHS was evaluated during FY 2001 using the Federal Worker 2000 Action Plan. The FY 1999 performance measure of 95% of safety and health deficiencies addressed in OPDIV corrective action plans was achieved. The organization evaluated during FY 1999 was the Centers for Disease Control and Prevention. Its corrective action plan exceeded the goal by addressing 100% of the identified deficiencies.

Measure 2 - Number of security audits conducted of HHS-owned, leased and delegated buildings to monitor compliance with the Department of Justice (DOJ) minimum level requirements. FY 2001 Target: 2.

This goal is being suspended for FY 2001 and FY 2002 because of staff reassignment.

Establishing Performance Targets: The target is based on the number of facilities, potential vulnerability and available resources.

Performance Report: The Department places a high priority on the safety and security of its employees. In that regard, annual on-site audits of OPDIV physical security procedures, including use of card access systems, are conducted on a random basis to ensure that applicable DOJ minimum level security procedures are currently implemented in HHS owned and managed facilities. During FY 2000, the performance measure for this goal was met through the conduct

of comprehensive on-site security audits of certain HHS facilities and a comprehensive review of all OPDIV building access procedures based on government-wide concerns identified by the General Accounting Office's report to Congress on breeches of security at Federal agencies and airports. The on-site audits were conducted at the Department's Headquarters, the Hubert H. Humphrey (HHH) Building (managed by the Office of the Secretary) and the NIH Complex in Bethesda, Maryland, and were based on a review of additional security enhancements implemented at these locations. The review of OPDIV building access requirements identified security procedures currently in place, as well as additional actions that could be implemented, without budget restrictions, if heightened security was required. In addition, as part of PDD-63 activities, we conducted a general analysis of current security procedures for the CDC Headquarters installation in Atlanta, Georgia, focusing heavily on procedures to deter the threat of bio-terrorism activities on laboratory facilities. In FY 1999, this goal was met through on-site security audits in the HHH Building and the Headquarters Building for the Public Health Service, the Parklawn Building (managed by the Program Support Center). In addition, as part of Y2K Day 1 activities, we reviewed security procedures for the CDC Headquarters installation in Atlanta, Georgia. Although the HHH and CDC facilities were reviewed in FY 1999, the importance of their Operations and security enhancements to the Department's evaluation process made their reinspection in FY 2000 critical. Each of these sites met or exceeded minimum security standards established by the DO in its Vulnerability Assessment of Federal Facilities.

DEPARTMENTAL APPEALS BOARD

FY 2004 PERFORMANCE PLAN

The Departmental Appeals Board (DAB) is an independent office established to provide conflict resolution services. Its mission is to provide the best possible dispute resolution services for the people who appear before us, those who rely on our decisions, and the public. These services are basically of two types: 1) adjudicatory hearings, appellate review of decisions of Administrative Law Judges (ALJs), and similarly structured formal and informal reviews of contested decisions; and 2) alternative dispute resolution (ADR), including mediation and other consensual processes and training related to ADR.

Organizationally, DAB has four Divisions:

- *The Appellate Division* supports the Board Members, issuing decisions on behalf of the Secretary of HHS in a wide variety of cases. In some cases, the Board provides a hearing if one is needed; in others, the Board provides an appellate-type review.
- *The Civil Remedies Division* supports ALJs who conduct hearings and issue initial decisions in health care fraud and abuse cases, provider sanction cases, and other civil enforcement cases.
- *The Medicare Operations Division* supports Administrative Appeals Judges (AAJs) who act as the Medicare Appeals Council for review of decisions by SSA ALJs in Medicare entitlement and coverage and payment cases (i.e., Medicare Appeals).

NOTE: The Board Members and other judges are part of the Immediate Office of the Chair of the Board (together with administrative support staff), but are considered part of the Divisions for purposes of GPRA, since their caseloads are identified to the Divisions.

- *The Alternative Dispute Resolution (ADR) Division* supports the Chair of the Board in her function as Dispute Resolution Specialist for the Department. The Division provides direct ADR services, such as mediation in Board cases and other Department disputes, and provides ADR training.

Since the mid-1990's, caseload sizes have grown very rapidly, particularly for the Civil Remedies and Medicare Operations Divisions. Caseload projections signal continued growth. In addition, cases are increasing in complexity, thereby requiring more time for analysis and decision-making. Finally, the use of ADR is expanding requests for mediation services have more than doubled over the past few years. The Performance Goals support and respond to other efforts (e.g., work redesign, improved data collection, increased staffing) to effectively carry out DAB's responsibilities and functions.

DM GPRA Performance Plans

Performance Goals	FY Targets	Actual Performance	Reference*
Goal 1: Maintain Appellate Division case processing rates as a measure of efficiency of Board proceedings. Measure: Percentage of Board decisions with net case age of six months or less.	FY04: 70% FY03: 70% FY02: 70% FY01: 70% FY00: 60% FY99: 80%	FY02: 86% FY01: 75% FY00: 81% FY99: 53%	
Goal 2: Maintain reversal and remand rate of Board decisions appealed to Federal courts as a measure of quality of decisions. Measure: number of decisions reversed or remanded on appeal to Federal court as a percentage of all Board decisions issued.	FY04: 2% FY03: 2% FY02: 2% FY01: 2% FY00: 2% FY99: 2%	FY02: 2% FY01: 2% FY00: 2% FY99: 2%	Outcome
Goal 3: Increase Civil Remedies case processing rates for Inspector General cases. Measure: percentage of decisions issued within 60 days of the close of the record.	FY04: 80% FY03: 80% FY02: 80% FY01: (new goal)	FY02: 83% FY01: 78% (baseline)	
Goal 4: Reduce average net case age for Civil Remedies Division decisions. Measure: average net days for cases from receipt to decision in target year compared to FY99. Goal 4 (beginning FY04) Constrain growth in number of aged Civil Remedies Division cases. Measure: number of cases open at end of Fiscal Year that were opened in previous Fiscal Years.	FY04: (see new goal) FY03: 15% FY02: 15% FY01: 15% FY00: 10% reduction FY99: N/A	FY02: 421 days (21% increase) FY01: 494 days (33% increase)* FY00: 406 days (18% increase) FY99: 332 days (baseline) FY02: 334 cases (baseline)	

DM GPRA Performance Plans

Performance Goals	FY Targets	Actual Performance	Reference*
Goal 5: Increase use of ADR (i.e., mediation) in Board-appealed cases, so as to increase efficiency and decrease contentiousness in case resolution. Measure: number of cases mediated in FY 2003 compared with number of cases mediated in FY 2002.	FY04: 5% increase over FY 2003 FY03: 10% increase over FY 2002 FY02: 10% increase over FY 2001 FY01: 10% increase over FY 2000 FY00: 25% increase over FY99 FY99: 25% increase	FY02: 36 (06%) FY01: 34 (14% increase) FY00: 29 for a 26% increase. FY99: 62 (23 used for measurement purposes for a 28 % increase) FY98: 18 cases (baseline)	Outcome
Goal 6: Maintain ADR training opportunities to increase awareness of alternative methods for handling conflict and to build conflict resolution skills. * Measure 1: number of sessions offered. Measure 2: number of HHS staff trained. (Measure will be dropped in FY04).	FY04: 12 FY03: 12 FY02: 12 FY01: 12 FY00: 9 sessions FY99: 6 sessions FY04: N/A FY03: 400 FY02: 400 FY01: 400 FY00: 400 FY99: 200	FY02: 18 FY01: 14 FY00: 15 FY99: 12 FY02: 242 FY01: 409 FY00: 435 FY99: 400 FY98: 150 (baseline)	
Goal 7: Encourage use of ADR throughout HHS. Measure 1: number of meetings and/or presentations with management and others, including Federal interagency efforts, to foster application of ADR techniques. Measure 2: number of HHS cases mediated through Sharing Neutrals.	FY04: 15 FY03: 15 FY02: 15 FY01: 15 FY00: 15 FY99: N/A FY04: 38 FY03: 36 FY02: 34 FY01: 30	FY02: 19 FY01: 18 FY00: 15 FY99: 12 (baseline) FY02: 30 FY01: 30 FY00: 28 (baseline)	

DM GPRA Performance Plans

Performance Goals	FY Targets	Actual Performance	Reference*
Goal 8: Constrain growth in average time to complete action on Medicare Appeals cases. (See rationale below) Measure: average time to complete action on Part B Requests for Review measured from receipt of case folder (FY 2001 and 2002).	FY04: 16 months FY03: 18 months FY02: 16 months FY01: 21 months	FY02: 15 FY01: 19 months FY00: 15 months FY99: 20 months (baseline)	
Goal 9: Increase number of dispositions of Medicare Appeals cases. (See rationale below). Measure: Number of dispositions.	FY04: 11,200 FY03: 10,800 FY02: 5,250 cases FY01: 5,000 cases	FY02: 12,336 FY01: 7,955 FY00: 4,435 (baseline)	
Goal 10: Increase Medicare Operations staff effectiveness through training. Measure: percentage of staff trained.	FY04: N/A FY03: 100% FY02: 100% FY01: 100% FY00: 100% FY99: N/A	FY02: 100% FY01: 100% FY00: 100% FY99: 80% (baseline)	

Goal 1: Maintain Appellate Division case processing rates

Measure: Percentage of decisions with a net case age of six months or less. Included in the count are cases where the Board declined review of an ALJ decision as well as decisions written by the Board.

Establishing Performance Targets: The Appellate Division reviews 1) determinations appealed directly to the Board in a wide range of cases, including disallowances under discretionary and mandatory grant programs, disapprovals of cost allocation plans, unilateral determinations of indirect cost rates, terminations of Head Start and other discretionary grants, sanctions in research misconduct cases, and determinations of ineligibility for ANA grants; and 2) appeals by either party of ALJ decisions in cases heard by the Civil Remedies Division, decisions by FDA ALJs, and decisions by ALJs in the Department of the Interior in cases involving the Indian Health Service's declination of proposed Indian Self-Determination Act contracts.

This goal addresses the timeliness of case review and decisions issued. The target for FY04 continues at 70%. The Division is unlikely to increase the level of case processing rates experienced in the last three years due to projected growth in the caseload and the departure of

one of the five Board members.

Performance Progress: Performance for FY 2002 exceeded the performance goal of 70% with 86% of the decisions having a net case age of six months or less.

Goal 2: Maintain the Appellate Division's reversal and remand rate on decisions appealed to the Board Federal courts as a measure of quality of decisions.

Measure: Number of decisions reversed or remanded on appeal to Federal court, as a percentage of all Board decisions issued (1,848 decisions by the end of FY 2002).

Establishing Performance Targets: This goal addresses the quality of Board decisions. Historically, 2% or less of all Board decisions have been reversed or remanded on appeal to Federal court. A performance target of 2% continues for FY 2004.

Performance Progress: The performance target for FY 2002 was met.

Goal 3 : Increase Civil Remedies Division case processing rates for Inspector General (IG) cases.

Measure: Percentage of decisions within 60 days of the close of the record.

Establishing Performance Targets: According to regulations, decisions on IG cases are to be made within 60 days of the close of the record. In actuality, that deadline is sometimes exceeded. This goal focuses on tracking and increasing the percentage of cases decided within 60 days. The target for FY 2002 is 80% of decisions made within 60 days of the close of the record. This target continues for FY 2003 and FY 2004.

Performance Progress: The FY 2002 target of 80% was exceeded (83%).

Goal 4: Reduce average net case age of Civil Remedies Division decisions.

Measure: Average net case age for cases to move from receipt to decision.

Establishing Performance Targets: This goal addresses timeliness. The target for FY 2000, the first year for this goal, was a 10% reduction in the average net case age for cases requiring a written decision. A target of 15% was set for FY 2003.

Performance Progress: The Civil Remedies Division did not meet its goal of reducing the average net case age, as currently defined, by 15% in FY 2001 and FY 2002 primarily due to staffing turnover. The Division lost senior staff, including three experienced ALJs, who were not fully replaced until the close of FY 2001. Because of the complex nature of the cases, most of FY 2002 was required for the new judges to reach ongoing productivity. Additionally, CRD

concentrated on closing older cases which correspondingly increased the average case age due to the longer processing times. Finally, data from our current database system cannot compute an actual *net* case age as the goal requires. The totals from FY01 (559) and FY02 (627) should be revised to read 494 (33%) and 421 (21%) days respectively (gross case age) since the previous calculations were incorrect.

Because of the difficulties in calculating the net case age and accounting for other factors affecting this computation, we are replacing Goal 4 for FY 2004 to reflect an emphasis on processing cases so as to constrain aging caseload numbers.

Goal 4 (new for FY 2004): Constrain growth in number of aged Civil Remedies Division cases.

Measure: number of cases open at end of Fiscal Year that were opened in previous Fiscal Years.

Establishing Performance Targets: FY 2002 serves as the baseline with 334 cases open at the close of FY 2002 that were opened in prior Fiscal Years.

Goal 5: Increase the use of Alternative Dispute Resolution (ADR) in Board cases to increase efficiency and reduce contention in case resolution.

Measure: number of cases mediated in a fiscal year compared to previous fiscal year expressed in percentages.

Establishing Performance Targets: This outcome goal is directed at expanding the use of ADR (i.e., mediation) in cases appealed to the DAB. Mediation, when successful, can resolve appeals faster and less expensively than the formal appeal process. Greater use of mediation also has the potential for reducing case backlogs.

In FY 1999, 63 cases were mediated; however, 40 of these cases represent a one-time appeal of a block of cases involving a unique cost allocation issue. For performance measurement purposes over time, DAB factored out this block, leaving a total of 23 cases mediated. A target of a 10% increase was established for FY 2002 and FY 2003. The FY 2004 is a 5% increase over FY 2003.

Performance Progress: Thirty cases were mediated in FY 2001, for a 14% increase over FY 2000, thus exceeding the goal. In FY 2002 the increase was 6%, less than the target. The total number of cases increased, however. The slower than expected rate of increase is partially the result of a leveling off of the rate of increase in the number of new cases in the Appellate and Civil Remedies Division, the pool of cases available for mediation. We expect to offset this decrease with more ADR activity in MOD and CRD cases in FY 2003.

Goal 6: Maintain ADR training opportunities to increase awareness of alternative methods of handling conflict and to build conflict resolution skills. *

This goal has been revised. It now reads "Maintain ADR training opportunities..." instead of "Expand ADR training opportunities..." The rationale for this change is explained below. The performance measures remain the same.

Measure 1: Number of training sessions offered.

Measure 2: Number of HHS staff trained.

Establishing Performance Targets: Increased use of ADR is the result of several factors: increasing the awareness of alternatives to the typical ways of dealing with conflict; understanding ADR processes and their potential use; and expanding the availability of trained neutrals. Identified measures address both the availability of training and the number of staff trained.

The target for Measure 1, number of sessions conducted, was 12 for FY 2002 and FY 2003. The same target of 12 session continues for FY 2004. The Measure 2 target for FY 2002 and FY 2003 is 400 staff trained. The target is shifted downward to 250 for FY 2004. This reflects the trend of fewer people attending ADR classes as the population of HHS employees that has not yet been trained grows smaller. This measure will be dropped for FY 2004.

Performance Progress:

Measure 1: 14 sessions were held in FY 2001, exceeding the target of 12. During FY 2002, 18 sessions were held.

Measure 2: 409 staff were trained in FY 2001, exceeding the target of 400. In FY 2002, the number of staff receiving training dropped to 242. This reflects a shift to smaller training sessions targeted to specific groups.

Goal 7: Encourage the use of ADR throughout HHS.

Measure 1: Number of meetings and/or presentations with management and others, including Federal interagency efforts, to foster the application of ADR techniques.

Measure 2: Number of HHS cases mediated through Sharing Neutrals.

Establishing Performance Targets: This goal supports the functions of the Department's Dispute Resolution Specialist; the Chair of DAB is designated as such by the Secretary.

Measure 1: Performance target FY 2002 and FY 2003 is 15 sessions; this target continues for FY 2004.

Measure 2: This measure, new in FY 2001, reflects the increasing demand for low-cost, qualified mediators and the role of Sharing Neutrals in meeting this demand. Sharing Neutrals is

administered by the ADR division. FY 2000 serves as the baseline; in that year, 28 disputes (in five OPDIVs and OS) were mediated through Sharing Neutrals. The target for FY 2002 was 34 cases, increasing to 36 cases mediated for FY 2003. A target of 38 cases is established for FY 2004 for an increase of 10 cases over the baseline.

Performance Progress:

Measure 1: The FY 2001 target was exceeded, in large part because of the ADR Division's leadership role in initiatives sponsored by DOJ and ABA to clarify confidentiality protections under the ADR Act and best practices in the Federal sector's ADR proceedings. The target was again exceeded in FY 2002.

Measure 2: The FY 2001 target was met. In FY 2002, the number of HHS cases mediated through Sharing Neutrals remained at 30 although the overall number of Sharing Neutrals cases increased.

Goal 8: Constrain growth in the average time to complete action on Medicare Appeals before the Medicare Appeals Council.

Measure: Average time to complete action on Part B Request for Review measured from receipt of case folder. This revises the previous measure to focus on the most numerous subset of cases.

Establishing Performance Targets: the target for FY 2004 has been revised downward, from 24 months to 16 months, to reflect new information. The target assumes delay of the implementation of the Benefits Improvement and Protection Act (BIPA), which was effective October 1, 2002 for Medicare appeals. Case disposition time will increase if MOD does not have sufficient resources to close cases on a current basis and if BIPA changes cause case receipts to increase over current levels. MOD is disposing of increasing numbers of cases, however, due to increased processing efficiencies and strategic planning initiatives related to its organizational redesign project. Performance measurement for FY 2003 will use the same criteria.

Performance Progress: MOD used gross case processing times as the measure for past fiscal years. However, it is more meaningful to look at case disposition time for cases that have a workable record for the most numerous subset of MOD cases, Part B Requests for Review. Therefore, for a more meaningful comparison, we have revised the measure and actual performance data for FYs 2001 and 2002 to reflect the time for disposition of Part B cases from receipt of the case file (i.e., from when the case was ready to work).

Goal 9: Increase Number of Dispositions.

Measure: Number of dispositions

Establishing Performance Targets: The target goal was revised to increase the number of dispositions for FY 2001 (5,000 dispositions) and FY 2002 (5,250). By increasing the number of

dispositions, the growth in the average case age may also be constrained for future years. We evaluated MOD case processing and are now implementing recommendations for improvements. As a result of the redesign efforts and some increase in staffing, DAB projected an increase to 5,250 dispositions in FY 2002. The FY 2003 target of 10,800 dispositions reflected staff increases that did not occur due to budget constraints. Despite not receiving all resources expected, we are leaving the target goal for FY 2004 at 11,200. Due to MOD case processing improvements, we expect to reach the 2004 goal.

Performance Progress: The actual number of dispositions in FY 2001 (7,955) and FY 2002 (12,336) exceeded projections for these years. This was due to continued implementation of MOD's reinvented case processing procedures and improved efficiencies. There were also remands, withdrawals, and court settlements that resulted in a large number of case closures.

Goal 10: Increase the effectiveness of MOD staff through training. (To be dropped in FY 2004)

Measure: Percentage of staff trained in at least two substantive areas. This is a revised measure, using percentages rather than numbers. Since the number of staff has fluctuated, DAB believes percentages will be a more effective measure.

Establishing Performance Targets: This target is 100% for FY 2002 and FY 2003. We propose to drop this goal for FY 2004.

Performance Progress: 100% of staff received training in FY 2001. The goal of 100% was met in FY 2002. Since training is ongoing, the goal is no longer needed.

Data Verification and Validity

Case data are entered in controlled-access databases, with case-specific identification. Other program data (e.g., number of training sessions, number of cases reversed or remanded) are also recorded and tracked. Data used in performance measures are validated by generating periodic reports. At the end of the fiscal year, the report totals will be cross-checked with annual totals for each measure.

OFFICE OF THE GENERAL COUNSEL

UPDATE ON DEVELOPING GPRA PERFORMANCE MEASURES

The General Counsel's personal performance contract includes the following intermediate outcome goals:

- Effectively manage legal challenges to HHS;
- Improve OPDIV and STAFFDIV confidence in OGC; and
- Provide timely advice and counsel.

To achieve these goals, OGC needs to establish a new infrastructure. Accordingly, OGC will establish a legal resource management unit which will include performance-based budgeting and legal resource and knowledge management principles and practices. OGC is moving toward a performance-based budget and knowledge management concept to:

- improve its understanding of what it does and how it does it;
- provide incentives for OGC offices to allocate resources and execute budgets with a focus on effectiveness (i.e., on performance, not process);
- align authority and resources with accountability for particular results; and
- improve results achieved by the Department, and make this transparent to the general public.

A first step must be the establishment of a centralized tracking system. Currently, OGC is able to track little more than half its workload (all regional, but only limited headquarters information). Therefore, OGC will need to use emerging technologies to implement decision management tools which will more effectively track workload, time and the general distribution of resources across OGC. This will enable OGC to bring legal research tools to its employees via the internet, and to measure the OGC workload more accurately. In addition, OGC will be able to review emerging workloads and deploy the work to practice groups, which will allow OGC the flexibility of determining workload vulnerabilities across OGC.

OFFICE OF PUBLIC HEALTH AND SCIENCE

FY 2004 PERFORMANCE PLAN

Executive Summary**Agency Mission**

The Office of Public Health and Science (OPHS) provides leadership on public health issues for women and minorities, the integrity of biomedical research, public health preparedness and emergency response, national health goals and objectives, use of the Internet and information technology for health, and White House and special Secretarial initiatives involving prevention programs and science. It is unique in the Department for its coordination of vital internal and public-private initiatives which either exceed the purview of individual HHS agencies or require a careful balancing of participants' roles and responsibilities. In sum, OPHS strengthens the Department's public health and science efforts and is noted for national leadership and highly targeted programs and services.

OPHS is led by the Assistant Secretary for Health (ASH), who oversees eleven program offices that conduct a variety of nationally recognized activities, including health communication for targeted audiences and the general public. OPHS activities also support and facilitate the work of many of the Department's Operating Divisions. OPHS consists of the Immediate Office of the ASH, the Office of the Surgeon General (OSG), the Office of HIV/AIDS Policy (OHAP), the Office of Population Affairs (OPA), the Office of Disease Prevention and Health Promotion (ODPHP), the President's Council on Physical Fitness and Sports (PCPFS), the Office of Minority Health (OMH), the Office on Women's Health (OWH), the Office for Human Research Protections (OHRP), the Office of Research Integrity (ORI), the Office of Military Liaison and Veterans Affairs (OMLVA), and the National Vaccine Program Office (NVPO). The ASH also guides and provides technical assistance to the ten Regional Health Administrators. The Office of Emergency Preparedness and the Office of Global Health Affairs reported to the ASH until mid-2002.

Overview of plan and performance report

New Plan. The FY 2004 GPRA plan takes a more focused look at the core contributions of OPHS to the nation and the Department in the areas of prevention, health disparities, and public health infrastructure. In these areas, drawn from the HHS strategic plan, improvements can only be achieved over time and through the contributions of many organizations inside and outside HHS. They require mobilizing not only government and the private sector, but communities and individuals. OPHS plays an invaluable role by strengthening the science base, shaping national policy, promoting effective partnerships, communicating strategically, and leading or coordinating key initiatives. The FY 2004 Plan sets ambitious goals and challenges OPHS to

demonstrate the impact of activities that enable long-term progress to be achieved.

The OPHS FY 2004 plan carries over many of the themes of the existing plan, for which reporting will continue until the data are complete. (Since the large majority of our current GPRA measures are Healthy People objectives, progress will continue to be reported through Healthy People 2010 mechanisms over the decade.) However, the new plan focuses on FY 2004 Presidential and Secretarial priorities and includes new measures for OPHS outcomes. The relationship of the new plan to the current plan is described generally in Part I: Overview of Performance Measurement; the details of the new plan, including the specific measures with baselines and targets, are presented in the first section of Part II: Goal by Goal Performance Measurement; reporting on current measures is presented in the second section (Program Performance Analysis) of Part II.

Note: Activities of the Office of Emergency Preparedness and the Office of Global Health Affairs are included in discussions of the current plan; however, since they are no longer part of OPHS, they are not included in the FY 2004 plan, and reporting on their activities will not continue beyond FY 2002.

Selected HHS Strategic Priorities and Objectives	OPHS Priority	Contributing OPHS Offices
Preventing Disease and Illness	Strengthening Prevention	National Vaccine Program Office, Office of Disease Prevention and Health Promotion, Office of HIV/AIDS Policy, Office of Minority Health, Office of Population Affairs, Office of the Surgeon General, Office on Women's Health, President's Council on Physical Fitness and Sports
Closing the Gaps in Health Care	Closing Health Gaps	Office of Minority Health, Office on Women's Health, Office of Disease Prevention and Health Promotion, Office of HIV/AIDS Policy, Office of Population Affairs, Office of the Surgeon General

DM GPRA Performance Plans

Improving Health Science; Protecting our Homeland; Realizing the Possibilities of 21 st Century Health Care	Strengthening the Public Health Infrastructure, including the national health information infrastructure, the research enterprise, and data collection	<i>National Vaccine Program Office, Office for Human Research Protection, Office of HIV/AIDS Policy, Office of Research Integrity, Office of the Surgeon General, Office of Military Liaison and Veterans Affairs, Office of Disease Prevention and Health Promotion, Office of Minority Health, Office on Women's Health</i>
---	--	---

OPHS Program Performance**Success Stories**

Office on Human Research Protections (OHRP) (Priority 1-d. Strengthen the health sciences research enterprise) Our best performing program is the Division of Compliance Oversight's (DCO) case review activities. The DCO has drastically reduced the number of open compliance cases and reversed the trend of cases pending review. While at NIH, the number of cases pending review increased year after year. The reduction is a direct result of increasing OHRP's resources after the June 2000 reorganization from NIH to OPHS.

Office of Minority Health (OMH) (Priority 3: Eliminate racial and ethnic disparities in health status and health care access and quality) The HHS Partnership with ABC Radio Networks & ABC Radio's Urban Advantage Network informs minority communities on ways to achieve better health and close the health gaps between them and the rest of the US population. It seeks to inform and educate African Americans about the health gap and empower individuals to adopt healthier lifestyles through a health information and education campaign entitled "Closing the Health Gap: Reducing Health Disparities Affecting African Americans." In FY 2002, in collaboration with OASPA, this new partnership was expanded and strengthened.

The President's Council on Physical Fitness and Sports (PCPFS) (Priority 1-b. Promote healthy lifestyles and behaviors.) The PCPFS President's Challenge Physical Activity and Fitness Awards Program is a long-standing school-aged program that continues to grow annually. Now with five presidential awards, the President's Challenge encompasses three main program areas: physical fitness, health fitness, and active lifestyle. By incorporating physical activity, we are giving all students an opportunity to achieve presidential recognition for adopting and maintaining a fit, active, and healthy lifestyle.

Office of Population Affairs (OPA) (Priority 3: Eliminate racial and ethnic disparities in health status and health care access and quality.) In partnership with the National Minority AIDS Fund, the family planning program awarded \$5 million in funds to existing family planning clinics directed at expanding existing or implementing new efforts to provide HIV prevention, counseling, testing, and referral services on-site. Thirty-four supplemental grant awards were

made to family planning providers in communities where racial and/or ethnic minorities are disproportionately impacted by HIV/AIDS. The projects are aimed at preventing HIV infection and providing access to early treatment for those who are identified as HIV positive.

Office on Women's Health (OWH) (Priority 1-b. Promote healthy lifestyles and behaviors.)

The *National Women's Health Information Center* (NWHIC) is the best performing OWH Program. The NWHIC provides health information and referrals to consumers of health care services, health professionals, educators, and students. NWHIC, launched in the fall of 1998, offers a single point-of-entry to over 4,000 publications and 2,000 organizations on more than 800 health topics; eight specialty sections, including women with disabilities, healthy pregnancy, violence against women, breastfeeding, young women's health, smoking cessation information, healthy body image, and minority women's health, including a Spanish-language section.

Office of Disease Prevention and Health Promotion (ODPHP) (Priority 1-b. Promote healthy lifestyles and behaviors.)

healthfinder®, the official cross-agency Federal health portal site developed by HHS, together with other Federal agencies, launched a new Spanish-language version of the site and one especially for children ages 8-12. In 2002, new resources for American Indians and Alaska Natives were developed. In 2002, visits to the healthfinder® site increased 20%. As for its goal of improving access to Federal health information specifically, healthfinder.gov now directs users to other Federal health web sites an average of 200,000 times each month.

Lessons Learned

PCPFS (Priority 1-b. Promote healthy lifestyles and behaviors.)

The Presidential Sports Award program which recognizes regular physical activity in any one of over 65 activities is being revised to encourage greater interest and participation. Although very sound in practice, the program has not reached its maximum potential because one commits to doing the activity at least three times a week which will result in a total commitment of four months. While the program is user friendly and easy to understand, there is still a high drop out rate. Enhanced motivational tips and marketing of the program to diverse audiences should improve participation.

OWH (Priority 2-1. Increase awareness of and attention to global health concerns and their effects on domestic issues.)

The least performing OWH program is the *OWH International Women's Health Initiative*. This initiative has not been successful for several reasons: in particular, priorities and leadership changes in the international women's health arena, both domestically and internationally, have contributed to this program's inactivity. OWH maintains some contact with the Women's Healthcare Group of the US-Mexico Binational Commission, although this activity also has been minimal since 2000.

Program Performance Measurement Summary Table

	Measures in Plan	Results Reported	Results Met	Unreported
FY 2000	40	29	13	11
FY 2001	43	19	12	24
FY 2002	43	11	6	32
FY 2003	43	NA	NA	NA
FY 2004 (new plan)	15	NA	NA	NA

OPHS GPRA Contact: Mary Jo Deering, Ph.D., Deputy Director for Health and Management, Office of Disease Prevention and Health Promotion, 738-G Humphrey Building, 202-260-2652, mdeering@osophs.HHS.gov.

Part I: Overview of Performance Measurement

Strengthening prevention, closing the health gap, and strengthening the public health and research infrastructures are complex national challenges. They reach beyond the control and responsibility not only of OPHS but of the Department and even the Federal government itself. Achievement is dependent on various health programs and providers, all levels of government, and the efforts of the private sector as well as individual contributions. External factors that affect outcomes include legislative and court decisions, education and social services, the availability of resources, and shifts in the economy and demographics. OPHS' contributions are in some instances the vital first step without which the success of other inputs would be diminished or in jeopardy; in other instances OPHS provides the leadership and "glue" that makes the difference in collective efforts.

OPHS selected similar performance measures across the three priorities that stimulate our eleven offices and the Regional Health Administrators to improve work which is at the core of our missions. The measures fall into five broad areas.

Shaping Policy at the Local, State, National, and International Level

- **OPHS influences policies, programs, and practices** at the through review, analysis, and advice on existing policy-related efforts as well as development, coordination, and implementation of new initiatives and activities. Recent hallmarks of OPHS's activities in this area are the *The Surgeon General's Call to Action to Prevent and Decrease*

Overweight and Obesity and a variety of other reports which translate state-of-the-art science into documents that are extensively read by legislators, the media, professionals and the public. OPHS provided editorial leadership and project management for *Information for Health: A Strategy for Building the National Health Information Infrastructure*, a report to the Secretary from the National Committee on Vital and Health Statistics' Workgroup on the National Health Information Infrastructure (NHII), which is framing Departmental and private sector activities on health information infrastructure.

Communicating Strategically

- **OPHS increases awareness, understanding, and action on the major public health concerns and health systems** through strategic communications to decision makers, health professionals, and those serving racial/ethnic minority communities to spur responsive policy and programmatic action. OPHS produces key reports, background papers, and journal articles. Through targeted print and electronic channels, OPHS facilitates the sharing of information from the field on best practices related to the public health improvement.
- **OPHS provides leading Internet portals which ensure that the general public and specific populations have high quality, reliable information for managing health and wellness.** Through internationally-recognized Web sites, such as 4Woman.gov and healthfinder.gov, OPHS offers selected resources to empower people to make sound decisions for themselves and their loved ones.
- **OPHS provides leadership in improving health communication and eHealth** through the Health Communication focus area of *Healthy People 2010*, and work to promote the quality of health Web sites, to measure and promote health literacy, and to promote balanced development of the national health information infrastructure (NHII) so that the NHII serves the public as well as professionals and supports prevention as well as treatment and administration.

Promoting Effective Partnerships

- **OPHS establishes and strengthens effective networks, coalitions, and partnerships to identify public health concerns and to stimulate and undertake innovative projects that solve them.** OPHS reaches out to professional groups, advocacy groups, international partners, nongovernmental organizations, and colleagues in Federal, State, tribal and local governments, engaging in collaborative work to assist in the identification of health concerns and problems and development of creative solutions.

Building a Stronger Science Base

- **OPHS promotes the collection of health data and the strengthening of data**

infrastructures to monitor the health of all Americans, especially specific populations for whom data sources have been weakest, to measure the effects of initiatives and interventions aimed at improving health, and ultimately to provide a sound basis for decision-making.

- **OPHS fosters service demonstration projects, evaluations, and other studies of interventions aimed at improving health and the health care system** to strengthen and expand the science base for decision-making, determine best practices, identify and overcome barriers to health, and assess program and intervention effectiveness. It helps set the research agenda through reports such as *Improving Minority Women's Health Research: Minority Women, Gaps, Issues, and Assessment of Ongoing Research, Concerns and Recommendations*.
- **OPHS strengthens the health sciences research enterprise** by protecting the integrity of the research underlying public health policy and clinical treatments, by ensuring that all institutions that conduct research supported by the Public Health Service have an understanding and commitment to research integrity and an administrative process for responding to allegations of scientific misconduct, by conducting oversight review of institutional investigations into alleged misconduct in science, and by monitoring institutional efforts to promote the responsible conduct of research. OPHS helps to instill confidence by the public and others in research involving human subjects by working to ensure the protection of human research participants in accordance with US laws and regulations.

Leading and Coordinating Key Initiatives Within or on Behalf of the Department

- **OPHS provides the coordination needed for agencies to work as "One HHS" on key Departmental priorities.** *Healthy People 2010*, the nation's third decade-long prevention initiative, harnesses the energies of all of HHS' public health agencies in pursuing and monitoring progress toward national goals and objectives. The development of the 2010 national health goals involved Federal, tribal, State, local and non-governmental organizations; the initiative drives health policy making in many States, communities and businesses; and provides the basis for curricula in many health professional schools. The Assistant Secretary for Health chairs *Healthy People 2010* Progress Reviews. OPHS led the development of the *HHS Blueprint for Action on Breastfeeding*. Other significant leadership includes the Department-wide effort to develop standards for Institutional Review Boards Accreditation, coordinated pandemic influenza planning, the HHS interagency Vaccine Communications Group, HHS Initiative to Eliminate Racial and Ethnic Disparities in Health, and the Departmental Minority Initiatives Coordinating Committee. In FY 2003 OPHS will coordinate the Secretary's program *Steps to a Healthier US*, which supports the President's *Healthier US* initiative. *Steps* will also focus on diabetes, asthma, and obesity.

- **OPHS coordinates Federal efforts that bridge Departments**, such as development of the statutorily mandated *Dietary Guidelines for Americans*, which provide the policy basis for all Federal nutrition education activities and are published jointly with US Department of Agriculture. HHS heads this effort for 2005, and OPHS provides the lead staff. On behalf of the Secretary, the Assistant Secretary for Health chairs the Quality Interagency Coordination Task Force, which addresses healthcare quality improvement across the Federal government. OPHS coordinates President Bush's *Healthier US* initiative that targets major risk factors such as physical activity and poor nutrition. Healthier US is supported by the Departments of Agriculture, Defense, Education, Housing and Urban Development, Labor, Transportation, and Veterans Affairs; the Environmental Protection Agency; and the General Services Administration
- **OPHS coordinates nationwide efforts in strategic areas**, such as the Minority AIDS Initiative.

FISCAL YEAR 2004 OPHS REPORT/ PLAN ROADMAP

OPHS GOALS →	Strengthening Prevention	Closing Health Gaps	Strengthening the Public Health Infrastructure
CROSSCUTTING FUNCTION AREAS			
1. Shape Policy at the Local, State, National and International Levels	Increase the number of local, State, national and international health policies that incorporate prevention elements identified by OPHS as effective. <u>Measure 1</u> : The number of communities, State and local agencies, Federal entities, NGOs and international organizations that adopt (or incorporate into programs) policies and recommendations generated or promoted by OPHS through reports, committees, etc.	Increase the number of local, State, and national health policies and initiatives that seek to reduce health disparities. <u>Measure 1</u> : The number of communities, NGOs, State and local agencies, and Federal entities, that adopt (or incorporate into initiatives) policies and recommendations targeting health disparities that are generated or promoted by OPHS through reports, committees, etc.	Increase the number of local, State, and national health policies, programs, and services that strengthen the public health and national health information infrastructures, and the number of policies in research institutions that improve the research enterprise. <u>Measure 1</u> : The number of communities, NGOs, State and local agencies, Federal entities, and research organization that adopt (or incorporate into programs) policies, laws, regulations and recommendations promoted or overseen by OPHS.

DM GPRA Performance Plans

OPHS GOALS →	Strengthening Prevention	Closing Health Gaps	Strengthening the Public Health Infrastructure
2. Communicate Strategically	Increase the reach of OPHS prevention communications. <u>Measure 1:</u> The number of visitors to Websites, inquiries to clearinghouses; <u>Measure 2:</u> number of regional/national workshops/conferences, community-based events, consultations with professional and institutional associations; <u>Measure 3:</u> new, targeted educational materials/campaigns; <u>Measure 4:</u> media coverage of OPHS-supported prevention efforts (including public affairs events)	Increase the reach of OPHS communications related to health disparities. <u>Measure 1:</u> The number of visitors to Websites, inquiries to clearinghouses; <u>Measure 2:</u> number of regional/national workshops/conferences; community-based events; <u>Measure 2:</u> new, targeted educational materials/campaigns; <u>Measure 3:</u> media coverage of OPHS-supported disparities efforts (including public affairs events) and estimated number of broadcast media outlets airing Closing the Health Gap messages.	Increase the reach of OPHS communications related to strengthening the public health, national health information and research infrastructures. <u>Measure 1:</u> The number of visitors to Websites, inquiries to clearinghouses; <u>Measure 2:</u> regional/ national workshops/ conferences, community-based events, consultations with professional and institutional associations; <u>Measure 3:</u> new, targeted educational materials/campaigns
3. Promote Effective Partnerships	Increase the number of substantive commitments to prevention on the part of governmental and non-governmental organizations. <u>Measure 1:</u> Number of formal IAAs, MOUs, contracts, cooperative agreements, and community implementation grants with governmental and non-governmental organizations that lead to prevention-oriented changes in their agendas/efforts.	<u>Increase the number of</u> substantive commitments to eliminating health disparities on the part of governmental and non-governmental organizations. <u>Measure 1:</u> Number of formal IAAs, MOUs, contracts, cooperative agreements, and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts to address health disparities.	Increase the number of substantive commitments to strengthening the public health, national health information, and research infrastructures on the part of governmental and non-governmental organizations. <u>Measure 1:</u> Number of formal IAAs, MOUs, contracts, cooperative agreements, and community implementation grants with governmental and non-governmental organizations that lead to changes in their agendas/efforts related to the public health, national health information, or research infrastructures.

DM GPRA Performance Plans

OPHS GOALS →	Strengthening Prevention	Closing Health Gaps	Strengthening the Public Health Infrastructure
4. Strengthen the Science Base	Increase knowledge about disease prevention and health promotion, including effective interventions and research needs. <u>Measure 1</u>: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; <u>Measure 2</u>: number of research demonstrations or evaluation studies completed and findings disseminated; <u>Measure 3</u>: the number of promising practices identified by research demonstrations, evaluation, or other studies.	Increase knowledge about health disparities, including effective interventions and research needs. <u>Measure 1</u>: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; <u>Measure 2</u>: number of research demonstrations or evaluation studies completed and findings disseminated; <u>Measure 3</u>: the number of promising practices identified by research demonstrations, evaluation, or other studies.	Increase knowledge about the public health, national health information, and research infrastructures, including research needs, and improve data collection needed to support public health decisions. <u>Measure 1</u>: Number of peer-reviewed texts (articles, reports, etc.) published by govt. or externally; <u>Measure 2</u>: number of research demonstrations or evaluation studies completed and findings disseminated; <u>Measure 3</u>: number of public health data enhancements (e.g. filling developmental objectives or select population cells; development of State and community data) attributable to OPHS leadership.
5. Lead and Coordinate Key Initiatives Within and on Behalf of the Department	Increase the impact of selected departmental, Federal and public-private collaborative efforts through effective OPHS leadership and coordination. <u>Measure 1</u>: Number of prevention-oriented initiatives/entities within HHS, across Federal agencies, and with private organizations that are convened, chaired, or staffed by OPHS; <u>Measure 2</u>: number of outcomes from efforts in measure one above that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.	Increase the impact of selected departmental, Federal and public-private collaborative efforts through effective OPHS leadership and coordination. <u>Measure 1</u>: Number of disparities-oriented initiatives/entities within HHS, across Federal agencies, and with private organizations that are convened, chaired, or staffed by OPHS; <u>Measure 2</u>: number of outcomes from efforts in measure one above that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.	Increase the impact of selected departmental, Federal and public-private collaborative efforts related to strengthening the public health, national health information, and research infrastructures through effective OPHS leadership and coordination. <u>Measure 1</u>: Number of infrastructure-oriented initiatives/entities within HHS, across Federal agencies, and with private organizations that are convened, chaired, or staffed by OPHS; <u>Measure 2</u>: number of outcomes from efforts in measure one above that represent unique contributions, as measured by non-duplicative programs, reports, services, events, etc.

Part II: Goal-by-Goal Performance Measurement**Program description and context**

Prevention, closing health gaps, and strengthening the public health infrastructure are interwoven priorities for the Nation, not just for OPHS. They require long-term strategies and collaborative, persistent action. Individuals are called on to make healthy choices for themselves and their families. Communities and businesses are challenged to support health-promoting policies in schools, worksites, and other settings. Research into not only the causes of health problems but also effective interventions must be completed and the findings widely shared. Health professionals and policy-makers must have access to data for sound decisions. Effective networks of information, communication, and services must underpin all approaches. OPHS's essential role in achieving each priority is to provide leadership, assess national health trends and problems, stimulate serious debate, engender creative ideas, and give critical visibility to health problems, needs, and solutions. OPHS seeks to ground efforts at the community level, calling on the serious involvement of civic and other local groups, community schools, and faith-based organizations to work in concert with the health system, both public and private. OPHS' direct efforts are measured through five cross-cutting strategies that are essential to achieving our priorities:

- strengthening the science base for decision-making by fostering data collection, research integrity, protection of human research participants, demonstration projects, and evaluations;
- shaping policy and programs at all levels of government;
- expanding and strengthening networks, coalitions, and partnerships to mobilize resources effectively;
- communicating strategically with various audiences to improve awareness, understanding, and action on the major health problems confronting Americans; and
- coordinating targeted initiatives across the Department to enable its components to act as "One HHS" and leading other high priority Federal and public-private efforts.

Strengthening Prevention Efforts

Preventing disease and illness requires reaching people in their homes, communities, schools and workplaces with information and programs that promote healthy lifestyles and with services that provide protection against health risks. OPHS is responsible for coordinating the President's health and wellness initiative, *Healthier US*, which uses all of the available resources of the Federal government to alert Americans to the vital health benefits of simple and modest improvements in physical activity, nutrition, and behavioral choices such as eliminating tobacco

and illegal drug use. OPHS also coordinates the Secretary's program, *Steps to a Healthier US*, which promotes healthy choices in nutrition, physical activity and preventive health care and seeks to reduce the risks our young people take. The Secretary's program will have a special focus on obesity, diabetes and asthma. OPHS manages *Healthy People 2010*, which sets out the science and the data to support national health improvement efforts. *Healthy People 2010* Progress Reviews, chaired by the Assistant Secretary for Health, provide an opportunity to monitor progress and identify challenges and solutions to key health issues. The *Healthy People 2010 Leading Health Indicators* are physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual activity, mental health, environmental health, injury and violence, immunizations, and access to care. OPHS offices play lead roles in specific activities related to physical activity, overweight and obesity, responsible sexual behavior, immunizations, environmental quality, and access to care.

OPHS Strategic Goal: Strengthen Prevention Efforts			
Performance Goals	Targets	Actual Performance	Reference
1. <u>Shape policy at the local, State, national and international levels.</u> OPHS will increase the adoption of effective prevention policies, as measured by the number of public and private entities at all levels that adopt policies as a result of OPHS efforts.	FY04: 39,160 FY03: 31,330	FY02: 30,053 FY01: 25,064	
2. <u>Communicate strategically.</u> OPHS will increase the reach of its prevention communications, as measured by customers served through Websites and clearinghouses, by professional and community-based outreach activities, and by targeted prevention communications.	FY04: 16,835,000 FY03: 15,607,000	FY02: 13,319,704 FY01: 11,462,477	
3. <u>Promote effective partnerships.</u> OPHS will increase substantive commitments to prevention on the part of public and private entities, as measured by the number of these entities that change or strengthen their prevention efforts as a result of partnership with OPHS.	FY04: 230 FY03: 205	FY02: 192 FY01: 180	

OPHS Strategic Goal: Strengthen Prevention Efforts			
Performance Goals	Targets	Actual Performance	Reference
4. <u>Strengthen the science base.</u> OPHS will increase knowledge about disease prevention and health promotion, including best practices and research needs, as measured by the publication of scientific reports and findings from research demonstrations and evaluation studies.	FY04: 19 FY03: 18	FY02: 16 FY01: 10	
5. <u>Lead and coordinate key initiatives with and on behalf of the Department.</u> OPHS will increase the impact of selected prevention activities through its leadership and coordination, as measured by the number of such efforts that are convened, chaired, or staffed by OPHS and the unique contributions of those efforts.	FY04: 199 FY03: 190	FY02: 188 FY01: 164	

Closing Health Gaps

OPHS supports the Department's efforts to address health disparities. *Healthy People 2010* sets a goal of eliminating racial disparities in health by 2010. For all the medical breakthroughs we have seen in the past century, we still see significant disparities in the medical conditions of racial groups in this country. What we have done through this initiative is to make a commitment to eliminate – not just reduce – some of the health disparities between majority and minority populations.

Eliminating disparities is not a zero-sum game. We are not taking anything from anyone when we ensure focus on the health needs of those most at-risk. We are operating on the premise upon which the Public Health Service was founded 200 years ago: The entire nation benefits when we protect the health of those most vulnerable.

OPHS plays a leading role in many efforts to eliminate disparities, including the Leadership Campaign on AIDS, Minority AIDS Initiative, Centers of Excellence in Women's Health and National Community Centers of Excellence in Women's Health, National Leadership Summits for eliminating racial and ethnic disparities in health, and the Minority Women's Health Panel of Experts. In addition, OPHS supports the Minority Male Health Project to focus on support for local, community efforts to combat chronic diseases affecting minority men. This program will collect, compile, and disseminate information on best practices for influencing minority male health behavior and ways to improve minority male access to health care.

OPHS communication efforts include Office of Minority Health Resource Center, National

Women's Health Information Center, and population-specific sections on 4Woman.gov and healthfinder® (including healthfinder® "español") and special resources for racial and ethnic populations.

OPHS Strategic Goal: Close Health Gaps			
Performance Goals	Targets	Actual Performance	Reference
1. <u>Shape policy at the local, State, national and international levels.</u> OPHS will increase the adoption of policies that seek to eliminate health disparities, as measured by the number of public and private entities at all levels that adopt policies as a result of OPHS efforts.	FY04: 40 FY03: 35	FY02: 30 FY01: 24	
2. <u>Communicate strategically.</u> OPHS will increase the reach of its communications that promote the elimination of health disparities, as measured by customers served through Websites and clearinghouses, by professional and community-based outreach activities, and by targeted communications.	FY04: 1,300,000 FY03: 1,200,000	FY02: 988,361 FY01: 1,154,517	
3. <u>Promote effective partnerships.</u> OPHS will increase substantive commitments to eliminating health disparities on the part of public and private entities, as measured by the number of these entities that change or strengthen their efforts as a result of partnership with OPHS.	FY04: 136 FY03: 132	FY02: 129 FY01: 124	
4. <u>Strengthen the science base.</u> OPHS will increase knowledge about health disparities, including best practices and research needs, as measured by the publication of scientific reports and findings from research demonstrations and evaluation studies.	FY04: 30 FY03: 20	FY02: 19 FY01: 14	

OPHS Strategic Goal: Close Health Gaps			
Performance Goals	Targets	Actual Performance	Reference
5. <u>Lead and coordinate key initiatives within and on behalf of the Department.</u> OPHS will increase the impact of selected activities through its leadership and coordination, as measured by the number of such efforts that are convened, chaired, or staffed by OPHS and the unique contributions of those efforts.	FY04: 25 FY03: 23	FY02: 20 FY01: 17	

Strengthening the Public Health Infrastructure

The tragedy of September 11th, 2001, underscored the urgent need to build a 21st century health support system that connects public health and healthcare professionals and the public to sound information and to each other. These networks of information, services, and people are the connective fabric of health improvement efforts. OPHS plays a vital role in building the data systems for understanding the health problems of our growing minority and ethnic populations; in promoting the integrity of the scientific research enterprise; and in promoting the development of a balanced national health information infrastructure that serves the public as well as professionals and supports prevention as well as treatment and administration.

OPHS activities in support of data development include the National Survey of Family Growth and Adolescent Health Survey, management of HP2010 and work with National Center for Health Statistics to collect and analyze national data on health status and health behaviors, co-chairmanship of the HHS Data Council's Working Group on Racial and Ethnic Data, and development of a new HIV/AIDS data methodology joining qualitative and quantitative data collection methods, known as RARE (Rapid Assessment, Response and Evaluation), including training for State and local health departments.

OPHS helps build capacity in State and local agencies and private organizations to support prevention. Some examples include the Leadership Campaign on AIDS to increase the capacity of minority community-based organizations to develop effective and innovative partnerships at the local level to enhance HIV/AIDS services and education and the State Minority Health Infrastructure Study, the National American Indian/Alaska Native Health Forum to identify strategies through which State, tribal, and Federal governments can complement and supplement their respective health systems.

OPHS contributions to the scientific research infrastructure include the Federal Research Misconduct Officials Network includes representatives from 27 agencies.

OPHS has had a lead role in the development of key documents and activities related to the

national health information infrastructure (NHII), which includes standards, applications, research with emphasis on linkages among consumers/patients, providers, and public health. ODPHP provides the lead staff to the workgroup on the NHII of the National Committee on Vital and Health Statistics, including development of the landmark report *Information for Health: a Strategy for Building the National Health Information Infrastructure* and organizing hearings to explore issues and opportunities for implementing the NHII.

OPHS Strategic Goal: Strengthen the Public Health Infrastructure			
Performance Goals	Targets	Actual Performance	Reference
1. <u>Shape policy at the local, State, and national levels.</u> OPHS will strengthen the public health, health information, and research infrastructures as measured by the number of public and private entities at all levels that adopt supportive policies, programs, services, laws, regulations, and recommendations as a result of OPHS efforts.	FY04: 360 FY03: 350	FY02: 351 FY01: 204	
2. <u>Communicate strategically.</u> OPHS will increase the reach of its communications that promote stronger public health, health information, and research infrastructures, as measured by customers served through Websites and clearinghouses, by professional and community-based outreach activities, and by targeted communications.	FY04: 41,150 FY03: 40,125* * One Website will be transferred in FY03	FY02: 48,813 FY01: 38,317	
3. <u>Promote effective partnerships.</u> OPHS will increase substantive commitments to strengthening the public health, health information, and research infrastructures on the part of public and private entities, as measured by the number of these entities that change or strengthen their efforts as a result of partnership with OPHS.	FY04: 36 FY03: 34	FY02: 51 FY01: 34	
4. <u>Strengthen the science base.</u> OPHS will increase knowledge about the public health, health information, and research infrastructures, including best practices and research needs, as measured by the publication of scientific reports and findings from research demonstrations and evaluation studies and by improving health data collection.	FY04: 100 FY03: 100	FY02: 80 FY01: 121	

OPHS Strategic Goal: Strengthen the Public Health Infrastructure			
Performance Goals	Targets	Actual Performance	Reference
5. <u>Lead and coordinate key initiatives within and on behalf of the Department.</u> OPHS will increase the impact of selected activities through its leadership and coordination, as measured by the number of such efforts that are convened, chaired, or staffed by OPHS and the unique contributions of those efforts.	FY04: 14 FY03: 13	FY02: 12 FY01: 7	

FY 2002 Program Performance Analysis

Most of OPHS' current GPRA measures are derived from *Healthy People 2010*, the third decade-long national prevention initiative. The objectives in *Healthy People 2010* were given ambitious targets; they are intended to represent public health challenges which might be achieved over the decade if all necessary resources of the public and private sectors were mobilized to address the specific issue. The experience of the prior decades demonstrates the difficulties in attaining these high public health goals: for *Healthy People 2000*, for example, the nation achieved or moved in the right direction on over 60% of the objectives.

Progress toward all the *Healthy People 2010* objectives will be monitored throughout the decade by Progress Reviews chaired by the Assistant Secretary for Health.

Current Priority 1: Ensuring a Balanced Community Health System

Section 1(a) FY 2002 Performance Summary: Goals 1.1-1.6

The birth rate for teenagers continued its steady decline since the early 1990s between 1991 and 2001 (the latest year for which data are available) there was a 35% drop in the birth rate for teenagers 15-17. The 2001 birth rate for teenagers 15-17 years fell 8% from 2000. The percent of women who began prenatal care in their first trimester of pregnancy increased slightly for 2000-2001, from 83.2 to 83.4%.

Within the larger public health framework, OPHS's Office of Population Affairs and the programs it administers (the AFL program and the Family Planning Program) play a central role in assuring a healthy start for every child by preventing unintended and adolescent pregnancies, providing abstinence education for adolescents, and providing related preventive health care and counseling.

In an effort to promote effective partnerships to reduce adolescent pregnancy, the AFL prevention projects continue to focus on abstinence as the most effective method of preventing

adolescent pregnancy and sexually transmitted infections. In FY 2002, the AFL program made available approximately \$6.5 million to support an estimated 35 prevention (abstinence education) projects.

In 2002, the family planning program, the primary provider of subsidized family planning services for low-income individuals, provided funding for service delivery grants to 91 public and private organizations supporting a nationwide network of more than 4,500 family planning clinics. Title X provides reproductive health services to approximately 4.4 million persons each year, enabling women to avoid unintended pregnancies. Pregnancy testing is a common and frequent reason for women coming to visit a clinic, and family planning is often an access point for women entering early prenatal care. The program also plays an important role in adolescent pregnancy prevention. In addition to clinical services, outreach and education (including counseling to encourage continued postponement of sexual activity for adolescent clients who are not yet sexually active) are important components of family planning services for adolescents.

The reduction of new perinatally acquired HIV infections has also been a high priority for the Department since the definition of effective treatment options that reduce the risk of transmission from mother to child. OPHS has coordinated a Department-wide effort across the research, prevention and treatment arenas to maximize opportunities to reduce the incidence of new perinatal HIV infections. HRSA, CDC and SAMHSA have extensive program efforts in place to reach and offer pregnant women with HIV infection effective treatment for their own illness and to reduce the risk of perinatal transmission. The US has seen dramatic reductions in perinatal HIV transmission rates in the past decade; these initiatives have been successful in dropping the number of new perinatal AIDS cases diagnosed each year, with 102 cases diagnosed in FY 2000 compared to a target level of 203 cases, well exceeding the target set. Surveillance data reported through December 2000 show sharply declining trends in perinatal AIDS cases, showing a reduction of 69 cases from the FY 1999 level of 171 cases (to 102 cases in FY 2000), or a 40% reduction; this decline was strongly associated with increasing zidovudine (ZDV) use in pregnant women who were aware of their HIV status, at delivery, and in treatment of the infant after birth. More recently, improved treatment also likely delayed onset of AIDS for HIV-infected children. These declines also reflect the success of widespread implementation of PHS recommendations for routine counseling and voluntary HIV testing of pregnant women. With efforts to maximally reduce perinatal HIV transmission and increase treatment of those infected, declines are likely to continue but may be affected by treatment failures and missed opportunities to prevent transmission.

Finally, in the area of influencing national policy, OPHS's Office on Women's Health led the development and publication of the HHS *Blueprint for Action on Breast-feeding* released by the Surgeon General. The *Blueprint* establishes a comprehensive policy for the nation to improve children's health by promoting the benefits of breast-feeding through the family and community, workplaces, and the healthcare system. Over 90,000 copies of the *Blueprint* have been distributed. In addition, collaborations have been formed with the American Association of

Health Plans, American College of Obstetricians and Gynecologists, and the African American Breast-feeding Association. In FY 2002 a National Breast-feeding Media Campaign and community outreach was launched with the Ad Council.

Performance Measures

Performance Measures	Targets	Actual Performance
1.1 New measure for 2001: Birth rate per 1,000 females aged 15-17 <i>Data source: National Vital Statistics System, CDC, NCHS.</i>	FY03: 23.1% FY02: 24.6% FY01: 26.1% FY00: 27.6%	FY02: 06/03 FY01: 25.3% FY00: 27.4%
1.2 Proportion of <u>all pregnant women</u> who begin prenatal care in the first trimester of pregnancy 16.6a <i>Data source: National Vital Statistics System, CDC, NCHS</i>	FY03: 84.9% FY02: 84.5% FY01: 84.1% FY00: 90%	FY02: 06/03 FY01: 83.4% FY00: 83.2%
1.3 Decrease the number of perinatally acquired AIDS cases 13.17 <i>Data based on 1999 HIV/AIDS Surveillance Report. Volume 12(2).</i>	FY03: 139 FY02: 141 FY01: 151 FY00: 203	FY02: 10/03 FY01: 02/03 FY00: 01/02
1.4 Proportion of mothers who smoke during pregnancy 16.17 <i>Data source: National Vital Statistics System, CDC, NCHS</i>	FY03: 7% FY02: 8% FY01: 9% FY00: 10%	FY02: 06/03 FY01: 12% FY00: 12.2%
1.5 Proportion of mothers who breastfeed their babies at 6 months <i>Data Source: Ross Laboratories</i>	FY03: 38% FY02: 36% FY01: 34%	FY02: 10/03 FY01: 32.5% FY00: 31%
1.6 Increase the number of children enrolled in regular Medicaid or SCHIP (State Children's Health Insurance Program) <i>Data Source: CMS administrative files.</i>	FY03: +1 million over 2002 FY02: +1 million over 2001 FY01: +1 million over 2000 FY00: +1 million over 1999	FY02: +1.200 million children FY01: +3.441 million children FY00: +1.679 million children

Section 1(b) FY 2002 Performance Summary: Goals 1.7-1.12

Through the Office of Population Affairs, OPHS contributes to departmental efforts to reduce the incidence of sexually transmitted diseases, specifically those addressed in measures 1.10, 1.11 and 1.12. Family planning clinics provide a broad spectrum of preventive health services in an effort to promote healthy lifestyles and behaviors. Title X family planning clinics provide services to a population that matches the demographics of the population of women most at risk for sexually transmitted diseases (STDs) and HIV infection – primarily young, low-income, and minority.

One example of OPHS's use of partnerships to promote healthy lifestyles and behaviors is the Title X Family Planning program's continued collaboration with the CDC to implement effective prevention strategies designed to reduce the prevalence of chlamydia and its debilitating complications. The effectiveness of large-scale screening programs in reducing chlamydia prevalence has been well documented in areas where this intervention has been in place for several years. CDC estimates that every dollar spent on early detection can save an estimated \$12 in complications-associated costs. The chlamydia prevention partnership, begun in 1987 as a demonstration project in PHS Region X, has now been expanded to all ten PHS regions. The success of this approach had been demonstrated by the fact that the chlamydia prevalence rate decreased by as much as 69% in Region X, where the program has been in place for more than ten years.

In OPHS, the President's Council on Physical Fitness and Sports (PCPFS) is involved in activities directly related to achieving performance measure 1.8, which addresses increasing physical activity among adults aged 18-74. In conjunction with the Healthy People 2010 objectives, the PCPFS continues to work with schools and outside organizational components to promote regular physical activities/fitness and non-competitive sports as positive, healthy behavioral patterns. To improve health behaviors related to physical activity and fitness, the PCPFS coordinates activities through its long-standing signature programs, the President's Challenge Physical Activity and Fitness Awards Program (for school and community-based achievement) and the Presidential Sports Award (for ages six to adult). In response to goals established by the HHS Initiative to Eliminate Racial and Ethnic Disparities in Health, the PCPFS translated materials on these two programs into Spanish and collaborated with the OMH clearinghouse for appropriate dissemination to Hispanic leaders, schools, and others. Efforts to build and strengthen coalitions and partnerships with minority organizations to enhance outreach to minority communities and youth will be addressed with the incoming administration's Council members.

The PCPFS promotes physical activity/fitness and sports through numerous partnerships and collaborative projects with Federal agencies and offices, as well as non-Federal organizations. The PCPFS publishes a quarterly periodical, *The President's Council on Physical Fitness and Sports Research Digest*, a synthesis of the latest scientific information presented in lay format, which is intended for use primarily by fitness, physical education, and allied health professionals. Otherwise, the PCPFS web site and publications are designed primarily for use by the general public. The PCPFS staff functions in an advisory capacity to provide technical

advice and assistance to individuals seeking funding, referrals to appropriate organizations, and other resource material about physical activity/fitness and sports. The PCPFS has a well-deserved national reputation as a credible voice calling for increased physical activity/fitness and sports by Americans of all ages and is in a unique position to address crosscutting issues, policies, and programs at Federal, State, and local levels.

Further, OPHS (ODPHP) led the creation of the *Leading Health Indicators* (LHIs), which contribute to meeting performance measures 1.7, 1.8, and 1.9, relating to tobacco use, physical activity, and drug/alcohol abuse, respectively. A report will provide the latest data used to monitor these issues on a national and State level. The LHIs are a special subset of measures based on objectives in *Healthy People 2010*.

Also, the Office of Disease Prevention and Disease Prevention has been forging unique public-private partnerships to achieve the goals of *Healthy People 2010* and improve the health of the nation. A number of strategic *Healthy People 2010* Partnership have been forged to catalyze health improvement. These formal partnerships have been developed with Federal, national, grassroots, and community organizations. Each partnership fundamentally changes or enhances the disease prevention or health promotion activities of the partnering organization and its members.

healthfinder® is the official cross-agency Federal health portal site developed by HHS, together with other Federal agencies. The Web site links to carefully selected health and human service information from over 1,800 Federal and State health agencies, nonprofits, voluntary and professional organizations, and other reliable non-commercial sources. In 2001, healthfinder® was redesigned and a new Spanish-language version of the site was released, along with one especially for children ages 8-12. In 2002, new resources for American Indians and Alaska Natives were developed with the extensive input of members of those communities. In 2002, visits to the healthfinder® site increased by 20% compared to the 2001. As for its goal of improving access to Federal health information specifically, healthfinder.gov now directs users to other Federal health web sites an average of 200,000 times each month.

Also, the HHS GirlPower! Campaign targeted at 9-14 year-old girls and the adults who care about them creates PSAs, programs, and activities to assist girls in realizing their full potential. A GirlPower! Community Education Kit has been designed to help those who work with girls to create programs with messages that girls have the right to be the best that they can be -- confident, fulfilled, and true to themselves. In FY 2002, Girl Power! has teamed with nearly 9,000 community based programs and organizations, more than 460 local endorsers and more than 62 national endorsers. The Girl Power! web site, www.girlpower.gov, has received more than 63 million hits since its launch in 1996.

Performance Measures

DM GPRA Performance Plans

Performance Measure	Targets	Actual Performance
1.7 Past month use of cigarettes by youth in grades 9-12 27.2b <i>Data Source: 1999 and 2001 Youth Risk Behavior Survey, CDC; 2000 and 2002, National Youth Tobacco Survey, CDC. HP2010 target is 16%.</i>	FY03: 32.0% FY02: 33.9% FY01: 35.9% FY00: 36.3% FY99: 36.4%	FY02: 10/04 FY01: 28% FY00: 28% FY99: 35%
1.8 Percent of people aged 18-74 who engage in at least moderate physical activity for at least 30 minutes per day, five or more times a week 22.2 <i>Data Source: National Health Interview Survey, CDC. HP2010 target is 30%.</i>	FY03: 19.5% FY02: 18% FY01: 26% FY00: 30% FY99: 29%	FY02: 12/04 FY01: 32.0% FY00: 31.9% FY99: 30%
1.9 Proportion of youth not using alcohol or any illicit drugs during the past 30 days 26.10a <i>Data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA. HP 2010 target is 89%.</i>	FY03: 89.5% FY02: 88.6% FY01: 88%	FY02: 12/03 FY01: 79% FY00: 80%
1.10 Proportion of young persons (15-24 years old) with <i>Chlamydia trachomatis</i> infections attending family planning clinics 25-1a <i>Data Source: STD Surveillance System, CDC. The HP 2010 target (for all young persons) is 3%.</i>	FY03: <5.0% FY02: <5.0% FY01: <6.0% FY00: <6.0%	FY02: 10/03 FY01: 5.8% FY00: 5.9%
1.11 Incidence of gonorrhea in women aged 15-44 (Per 100,000) <i>Data Source: STD Surveillance System, CDC.</i>	FY03: <250 FY02: <250 FY01: <250 FY00: <250	FY02: 10/03 FY01: 286.2 FY00: 284
1.12 Incidence of congenital syphilis per 100,000 live births 25.9 <i>Data Source: STD Surveillance System, CDC. HP2010 target is 1.00.</i> Expressed per 100,000 live births	FY03: <12 FY02: <12 FY01: <18 FY00: <19	FY02: 10/03 FY01: 11.1 FY00: 13.4

Section 1(c) FY 2002 Performance Summary: Goals 1.13-1.17

The Office of Women's Health partnered with the American Psychological Association to convene a Summit on Women and Depression in October 2000 - another example of OPHS partnership activity. This summit confirmed that translating the research into practice,

community interventions, and policy continues to be difficult. It served as a prelude to the meeting held in February 2002 on the "Psychosocial and Behavioral Factors in Women's Health: Enhancing Outcomes in Women's Health." Over 1,000 participants attended this interdisciplinary conference that featured 11 special panels which centered on the specific disease which are today's major killers and causes of disabilities of women.

Performance Measures

Performance Measure	Targets	Actual Performance
1.13 The proportion of people 18 and over reporting depression in the past 12 months who are receiving treatment 18.9a <i>Data source: National Comorbidity Survey (NCS), SAMHSA, CMHS; NIH, NIMH. The HP2010 target is 50%.</i>	FY03: 36% FY02: 34% FY01: 32%	FY02: 12/03 FY01: DNC FY00: 01/03
1.14 Proportion of injurious suicide attempts among youth grades 9-12 18.2 <i>Data source: Youth Risk Behavior Survey, CDC. HP2010 target is 1.0.</i>	FY03: 1.2 FY02: 1.4 FY01: 1.6 FY00: 1.8	FY02: 08/03 FY01: 01/03 FY00: DNC
1.15 Annual rate of suicide 18.1 <i>Data source: National Vital Statistics System, CDC, NCHS. The target for 2010 is 6.0 per 100,000 population. Note: target changed to 11.3 due to reference change</i>	FY03: 9.0 FY02: 9.5 FY01: 10 FY00: 10.5	FY02: 09/04 FY01: 09/03 FY00: 03/03
1.16 Violent victimization inflicted by current or former intimate partners. 15.34 <i>Data source: National Crime Victimization Survey, DoJ, Bureau of Justice Statistics. Healthy People target is 3.3 per 100,000 persons greater or equal to 12 years of age.</i>	FY03: 4.2 FY02: 4.3 FY01: 4.4 FY00: 7 (per 1,000 women)	FY02: 10/03 FY01: DNC FY00: 2.9
1.17 Develop a model metropolitan mental health response plan for a Weapons of Mass Destruction (WMD) terrorist incident, for inclusion in local disaster preparedness systems <i>Data source is OPHS administrative files.</i>	FY00: 1	FY00: 1 (Goal met)

Section 1(d) FY 2002 Performance Summary: Goals 1.18-1.25

The Office of Research Integrity (ORI) took several steps in FY 2002 to build a stronger science

base by (1) reviewing the 30 grant applications submitted in response to the second request for applications in its Research Program on Research Integrity; (2) initiating a program to produce resources that can be used in instruction in the responsible conduct of research (RCR); (3) continuing to conduct oversight reviews of institutional investigations of research misconduct allegations; (4) reviewing institutional policies for responding to research misconduct allegations; (5) co-sponsoring seven conferences or workshops; and (6) completing studies on fostering integrity in research environments and the feasibility of developing consortia to promote RCR.

In addition, ORI planned the Second Research Conference on Research Integrity that was held November 16-18, 2002 in the Washington area. Fifty abstracts were submitted and reviewed for the conference. Proceedings from the first conference were published and posted on the ORI website. ORI also announced an RCR Resource Development Program to stimulate the development of RCR resources by researchers and institutions and began working on a cooperative agreement with the Association of American Medical Colleges to facilitate the creation of RCR resources by academic societies. Besides the domestic conferences and workshops, ORI staff helped organize and participated in an international conference in Warsaw on conflict of interest in research that drew attendants from 26 countries and started planning an international conference that will be held in Puerto Rico in February 2003 on the use of human subjects in research.

OHRP program activity also contributes to strengthening the health sciences research enterprise. In FY 2002, OHRP's Division of Compliance Oversight (DCO) conducted three compliance oversight site visits (Brookhaven National Laboratory, National Institutes of Alcohol Abuse and Alcoholism, and the State University of New York at Brooklyn). Additionally, DCO opened 38 new compliance oversight cases and closed 101, in FY 2002. The number of open cases was reduced from its peak of 182 in July 2000 to 54 as of January 1, 2003.

ORI incorporated public comments into a revision of the proposed regulation on the protection of whistleblowers in research misconduct cases. In addition, ORI expects to recommend action on the suspended PHS Policy on Instruction in the Responsible Conduct of Research in early 2003 following consultation with the research community and PHS agencies. The Institute of Medicine report on *Integrity in Scientific Research: Creating an Environment That Promotes Responsible Conduct* (commissioned by ORI in 2000) was published in September 2002. A town meeting was held at the National Academy of Sciences on October 10, 2002 to present the findings to the research community and discuss the implementation of the recommendations.

ORI sponsored a conference on *The Role of Institutional Rules, Guidelines, and Education in Promoting the Responsible Conduct of Research* in Philadelphia on September 23-24, 2002 as part of a threefold effort to stimulate the research community to consider the advisability of developing research guidelines. The conference is a follow-up to a study of research guidelines adopted by medical schools that was supported by ORI. A resource document for developing research guidelines is being prepared. In addition, ORI is seeking OMB clearance for a study of

the incidence of research misconduct in biomedical research; monitoring the data collection and analysis of research integrity measures utilized in biomedical research laboratories, and collaborating with NIH in developing a preliminary evaluation of the research ethics requirement in research training grants supported by NIH.

The Institute of Medicine produced a report in April 2001 outlining standards for Institutional Review Boards to achieve accreditation. Under the leadership of OHRP, a process to develop standards for IRB Accreditation was developed using a unified IRB Registration System accessed through the internet. Since that time, OHRP has processed approximately 950 IRB registration. Building on the IRB Registration System, OHRP completed the pilot testing of a Quality Improvement Program (QIP), including a Self-Assessment Tool for research institutions. The new program, utilizes a case-based reference model to allow institutions to compare their performance with comparable programs. In FY 2002, OHRP implemented Stage 1 of the QIP, conducting a total of 25 QIP on-site consultations including 6 institutions in South Africa. OHRP has begun development of Stage 2 (Quality Improvement) of the QIP.

ORI and OHRP are also working with partners to improve communications aimed at strengthening the health sciences research enterprise. In FY 2002, ORI held seven conferences/workshop on research integrity and research misconduct, in collaboration with scientific societies and professional and institutional associations.

Universally, education is recognized as one of the most important elements in improving protections for human research subjects. In FY 2002, the OHRP conducted 85 educational presentations on human protections topics, six National Workshops (partnering with FDA/VA/NIH/NSF), and four Town Meetings (three via video-conferencing, two domestic and one international). OHRP expanded its outreach efforts by designing a new exhibit booth and staffed it at 4 professional meetings as well as at all OHRP National Workshops. OHRP also conducted Human Research Protections Workshops at two professional meetings, set up an e-mail Q&A mailbox and answered approximately 1200 inquiries from the research community.

OHRP will continue to exercise international leadership promoting protection of human research subjects around the world. Specific international accomplishments during 2002 include: initiating development of departmental guidance explaining criteria for implementation of the rulings of "at least equivalent protections" provisions of 45 CFR.101(h); participating in ten international meetings across five countries (South Africa, China, Thailand, Kazakhstan and Uruguay) representing Departmental polices to promote a culture of human research subject protection; partnering with the World Health Organization (WHO) to provide technical and fiscal support for four international workshops in Asia, Latin America, Russia, and Africa, to bolster the human and institutional capacity for ethical review in and for developing countries.

ORI took steps to facilitate communication with institutional officials, journal editors, and researchers during FY 2002. Listservs were established for institutional research integrity officers, researchers and RCR instructors. A program was initiated to develop posters that

communicate messages related to research integrity and the responsible conduct of research. The use of global email messages has also increased to quickly communicate with pertinent populations. ORI continued to work with the Council of Science Editors to organize a workshop for journal editors.

Performance Measures

Performance Measure	Targets	Actual Performance
1.18 Number of collaborative activities (workshops, publications and other resource materials produced) that assist institutions to (1) promote integrity in the health science research enterprise, and (2) develop administrative processes that effectively respond to allegations of scientific misconduct <i>Data Source: OPHS administrative files</i>	FY03: 4 workshops, 1 resource FY02: 4 workshops and 2 resources FY01: 4 workshops and 2 resources FY00: 4 workshops and 2 resources	FY02: 7 workshops, 1 resource FY01: 5 workshops, 2 resources FY00: 5 workshops and 1 resource
1.19 Percent of institutional policies for responding to allegations of scientific misconduct that have been reviewed for compliance with the Federal regulation 42 CFR Part 50, Subpart A <i>Data source: OPHS administrative files</i>	FY03: 45% FY02: 45% FY01: 40% FY00: 40%	FY02: 43% FY01: 41% FY00: 37%
1.20 Rate of completing ORI oversight of scientific misconduct cases within eight months of receiving final decision from institution <i>Data source: OPHS administrative files</i>	FY03: 80% FY02: 80% FY01: 75% FY00: 70%	FY02: 72% FY01: 78% FY00: 81% (completed in 8 months) FY99: 79% (completed in 1 year)
1.21 Implement an RCR education program for all persons receiving PHS research or research training support <i>Data source: OPHS administrative files</i>	FY03: Develop instructional resources program FY02: Develop a self-instruction manual FY01: Publish policy; hold 2 workshops	FY02: draft RCR guide under review FY01: Published policy, held 2 workshops
1.22 Create program on research on research integrity	FY03: Make up to 8 new awards;	FY02: 9 new awards

DM GPRA Performance Plans

Performance Measure	Targets	Actual Performance
<i>Data source: OPHS administrative files</i>	continue up to 5 awards FY02: Make up to 5 new awards; continue up to 5 awards FY01: Announce program; make up to 5 awards	FY01: Made 7 new awards FY00: Program announced
1.23 Number of compliance oversight site-visits to evaluate allegations of non-compliance with the Federal regulations at 45 CFR Part 46 <i>Data Source: OPHS administrative files</i>	FY03: 8 FY02: 8 FY01: 6	FY02: 3 FY01: 4 FY00: 4
1.24 Number of OHRP compliance oversight cases completed <i>Data source: OPHS administrative files</i>	FY03: 75 FY02: 75 FY01: 75	FY02: 101 FY01: 96 FY00: 60
1.25 Guidance from NHRPAC on number of significant issues <i>Data source: OPHS administrative files</i>	FY03: 4 FY02: 5 FY01: Establish NHRPAC	FY02: NHRPAC charter expired and not renewed FY01: NHRPAC established

Current Priority 2: Maintain a Global Approach To Public Health**Section 2(a) FY 2002 Performance Summary: Goals 2.1-2.2**

OPHS no longer includes the Office of Global and Health Affairs, which contributed many of the accomplishments in this area. Moreover, the two performance measures themselves are not directly within the purview of any OPHS office. Nevertheless OPHS will continue to report on efforts to support global health improvement through the current GPRA plan.

One of the most prominent and important areas of OPHS activity during FY 2002 was provision of senior staff support for HHS leadership (especially the Secretary, Deputy Secretary and ASH) in a variety of high-profile international events. In essentially all multilateral fora, the US position prevailed and was reflected in new international declarations, resolutions and policies.

Perhaps the most important example of effective OPHS activity in a multilateral setting is its staff support to the new Global Fund to Fight AIDS, Tuberculosis, and Malaria, a global initiative conceived by UN Secretary General Kofi Annan and supported by President Bush. OPHS provided senior policy and technical support to the development of the Fund's architecture and operating principles, coordination of technical review of proposals, and ultimately meetings of the Fund's Board. The HHS Secretary is the chief US representative to the 18-member Board.

The HHS Secretary also leads the US Delegations to the World Health Assemblies, the annual WHO gathering of health ministers. Through this leadership role and with OPHS senior staff support, the Department has worked hard to be viewed by WHO and countries alike as a fellow "Member State" rather than as a "donor country." Preparation for the WHA is a dynamic process that includes close coordination with HHS, DOS, and USAID experts and other stakeholders throughout the year in the development of US policy positions and programmatic strategies. For the 55th World Health Assembly in May 2002, agenda items included biological and chemical terrorism, smallpox virus retention, polio eradication, HIV/AIDS, infant and child nutrition, dengue, essential medicines, among others.

During FY 2002 OPHS provided critical support for the Secretary in creating and then his and the Deputy Secretary's participating in, respectively, the November 2001 and March 2002 meetings of a new Global Health Security Action Group addressing international cooperation on bioterrorism. Another example is OPHS support for the ASH's participation in the meeting of Health and Environment Ministers of the Americas in Ottawa in March 2002. Another is OPHS support for preparations for and then participation at the May 2002 UN General Assembly Special Session on Children, to which the Secretary led the US Delegation. OPHS also provided critical staff support to the Secretary as he led a Presidential Mission to Africa in April 2002 to see first hand the problems of HIV/AIDS, tuberculosis and malaria, and also helped the Secretary organize and execute a meeting of Caribbean health officials in Guyana (April 2002) to address the problem of HIV/AIDS in the Caribbean.

During FY 2002, OPHS continued to support and enhance the Department's global health website, *globalhealth.gov*, to provide useful and timely information to a wide range of audiences both inside and beyond the United States.

The US-Mexico Border Health Commission (USMBHC) was established in July 2000 between the Department of Health and Human Services and the Mexican Ministry of Health. OPHS coordinates the HHS side of the collaboration. The Commission institutionalizes a domestic focus on border health and creates an effective venue for binational discussions on health issues affecting the US-Mexico border populations. The Commission has established the Healthy Border 2010 Program, a mutually accepted agenda that addresses more than 12 focus areas, with more than 20 measurable health objectives for health improvement. Activities of the USMBHC encompass all four of OPHS' cross-cutting strategies related to science, policy, partnerships and communications.

During FY 2002, OPHS, working through the US Agency for International Development (USAID), continued its longstanding partnership in health with Egypt. The current agenda is centered around the *Healthy Egyptians 2010* initiative, adapted from the US experience with *Healthy People 2000*, launched in September 2000 and focused on four public health areas: Maternal and Child Health; Injury Control; Environmental Health and Tobacco Control. The *Healthy Egyptians 2010* collaboration will continue for an additional 2-5 years under USAID support. A mid-term review of HE2010 targets will be undertaken in FY 2004-05.

Another example of global partnership supported through OPHS is the HHS Biotechnology Engagement Program (BTEP), which began in 1999 to "engage" former Soviet bioweapon scientists in cooperative research. With the national security importance to this non-proliferation activity in mind, OPHS receives a funding stream of approximately \$25 million over three years. The vast majority of this funding (70%) is intended for Russian and NIS scientists and former weapons institutions. New research projects were submitted, reviewed, approved and initiated during FY 2002.

Many OPHS offices are involved in efforts to increase attention to global health concerns. The Office on Women's Health disseminated the technical manual *Caring for Women with Circumcision* to all medical, osteopathic, nursing, and public health schools in the US. Additionally, this manual was distributed to interested international organizations, as well as State, territorial, and regional women's health coordinators. During FY 2002, over 1000 copies of the manual were distributed. OWH, also in collaboration with the HHS Working Group on Female Genital Cutting (FGC), continues its efforts to educate and inform health professionals and the public about female genital cutting (FGC). In FY 2002, OWH continued to provide FGC resources through the National Women's Health Information Center.

OWH is also working on the expansion of the Women's Health Workgroup of the US-Mexico Binational Commission to include issues relative to the full range of a woman's life, of which the reproductive phase is a cycle. This expansion is essential in accomplishing the task of

providing more than minimum health care for women in the US and Mexico states that border both countries. In FY 2002, the Women's Health Services in Sante Fe, New Mexico was selected as the newest Community Center of Excellence.

Performance Measures

Performance Measures	Targets	Actual Performance
2.1 New cases of polio (world) <i>Data source: WHO Commission for the Certification of Polio Eradication (complete eradication expected in 2005)</i>	FY03: 0 FY02: 0 FY01: 0 FY00: 0	FY02: 1729 FY01: 537 FY00: 2,971
2.2 Tuberculosis case rate per 100,000 (USA) <i>Data source: Infectious disease surveillance system, CDC. Healthy People 2010 target is 1.0 new cases per 100,000 population (ie "elimination")</i>	FY03: 2.5 FY02: 2.8 FY01: 3.2 FY00: 3.5	FY02: 03/03 FY01: 5.6 FY00: 5.8

Section 2(b) FY 2002 Performance Summary: Goals 2.3-2.7

OPHS no longer includes the Office of Emergency Preparedness, which contributed most directly to the goals in this area. However, activities through the first half of 2002 are included here.

OPHS helped coordinate the government's response to the demands placed on the United States blood supply by the events of September 11, 2001. OPHS activities in this area include preparation for a meeting of the HHS Advisory Committee on Blood Safety and Availability on January 31 and February 1, 2002 to discuss what lessons can be learned from the events of September 11, 2001 that could improve the safety and availability of the United States blood supply.

OPHS continued to address potential widespread public health threats, including the threat of an influenza pandemic.

NVPO coordinated pandemic influenza planning to improve ongoing efforts for the prevention and control of influenza in the United States. Included in these efforts is the development of the Pandemic Influenza Action Plan. The goal of this plan is to limit the total burden of disease caused by an influenza pandemic, including social disruption and economic loss. To achieve this goal, three objectives are identified: strengthen global and domestic surveillance capabilities to increase the likelihood of early detection of an influenza pandemic and effective tracking of its spread, strengthen national readiness to respond to an influenza pandemic, and strengthen the infrastructure on which the plan depends.

In addition to the threat of an influenza pandemic, OPHS continued to prepare for other potential

public health disasters. The primary mission of the Office of Emergency Preparedness (OEP) is to assist in the management and coordination of the Federal health, medical and health-related social service response and recovery to major emergencies, Federally declared disasters and terrorist acts. As such, OEP directs a major national initiative, the Metropolitan Medical Response System (MMRS) development program, which provides a mechanism to forge a local integrated response which links multiple local, State and Federal agencies as well as private health care institutions that will serve as the initial responders to any weapon of mass destruction (WMD) event.

Performance Measures

Performance Measures	Targets	Actual Performance
2.3 Number of Metropolitan Medical Response Systems (MMRS) <i>Data Source: OPHS administrative files</i>	FY03: 122 FY02: 122 FY01: 97 FY00: 72	FY02: 122 FY01: 974 FY00: 72
2.4 Number of Metropolitan Medical Response Systems (MMRS) with bioterrorism capabilities <i>Data Source: OPHS administrative files</i>	FY03: 122 FY02: 97 FY01: 72 FY00: 47	FY02: 97 FY01: 72 FY00: 47
Blood Safety Measures		
2.5 Proportion of the estimated 300,000 living recipients of blood and blood products who have been notified of their potential hepatitis C exposure <i>Data source: FDA. FDA blood safety inspections that include Hepatitis C lookback began in October 2001.</i>	FY02: 100% FY01: 100% FY00: 100%	FY02: 03/03 FY01: 100% FY00: ~30%
2.6 The amount of adequate reserve quantities of immunoglobulin product for domestic use, as determined by the monthly report of the Plasma Products Therapeutics Association, which monitors statistics on US distribution and size of the emergency supply of plasma derivative products <i>Data source: FDA</i>	FY03: 76kg FY02: 76kg FY01: 76kg FY00: 76kg	FY02: 03/03 FY01: 76kg FY00: 76kg
2.7 Qualitative narrative describing the effectiveness of the rapid communication procedure for notification of the Blood Safety Director and members of the Blood Safety Committee for important developments related to blood safety from OPDIVs	FY03: 1 FY02: 1 FY01: 1 FY00: 1	FY02: 03/03 FY01: 1 FY00: 1

Current Priority 3: Eliminate Racial and Ethnic Health Disparities**Section 3 FY 2002 Performance Summary: Goals 3.0-3.11**

Several efforts have been undertaken within OPHS to eliminate the disproportionate burdens of disease carried by racial and ethnic minority populations.

OWH funded four National Centers of Leadership in Academic Medicine (COL), including one at Meharry Medical College that served as a demonstration project. These Centers had the following goals: (1) to foster gender equity in medicine, and (2) to promote the leadership advancement of junior faculty, who tend to be disproportionately women and minorities, into senior faculty positions. Over 100 professional publications/manuscripts, and presentations have been developed by the four Centers. Each Center institutionalized their program by placing the administration of their programs in the Office of the Dean and by providing financial contributions to continue these programs. In 2002, the Center directors served as advisors on career development and mentoring for the National Centers of Excellence in Women's Health and other academic centers. This fostered the duplication of the COL model into other academic centers. Initial evaluation of the Centers has revealed that they have contributed to the retention and recruitment of faculty into their institutions and have contributed to career satisfaction amongst their faculty. Final technical reports will be completed by the end of January 2003 when the contract expires.

The National Women's Health Information Center (NWHIC) created a specialty section on its 4woman.gov web site specifically geared to help women learn more about the leading health concerns of minority women. It puts a wealth of useful information together in one place for minority women, caretakers, health professionals, and researchers. This section does not deal only with illness and disease; it takes a proactive approach to health by featuring a "Nutrition and Wellness" section dealing with issues such as exercise and nutrition.

To increase awareness of the National Women's Health Information Center (NWHIC) to medically underserved populations, OWH has engaged in a series of marketing/promotional activities and partnerships. Consultorio Comunitario, The Community Clinic of the Air (Dr. Elmer Huerta), a daily, live phone-in Spanish-language radio talk show in which listeners ask Dr. Huerta questions directly, was dedicated in part to promoting National Women's Health Week and NWHIC as a health resource for women the week of May 12-18. In addition, during the summer of 2002 advertisements were run on the Urban Radio Networks which targets African American listeners. Another activity is the purchase and placement of bus cards advertising NWHIC in six major cities. Finally, the popular, "A Lifetime of Good Health" booklet, will be translated in Spanish and distributed broadly.

OPHS continued a number of activities to promote the collection of health data and the strengthening of data infrastructures, in order to enable the identification and monitoring of health status among US racial and ethnic minorities, the nature and extent of health disparities

affecting them, and the effects of initiatives and interventions targeting their health problems. For example, OMH co-chairs the HHS Data Council's Working Group on Racial and Ethnic Data, the internal advisory group to the Secretary on minority health data and statistics. OMH maintains the *HHS Directory of Minority Health and Human Services Data Resources* (Inventory) of 182 major data collection systems sponsored by HHS. The Inventory provides a snapshot of the HHS data collection systems that make their data available to the public. The Inventory is produced for policymakers, administrators, researchers, and the public as a reference document on data resources within HHS and is available on ASPE's website (<http://www.aspe.os.HHS.gov/datacncl/datadirectory>).

In FY 2000, OMH conducted a preliminary review of State laws and regulations which prohibit the collection of racial and ethnic data by health insurers and HMOs in the private market. In FY 2001, Phase I of this project – involving the review of State laws, regulations, and other written policies regarding the collection of racial and ethnic data in health care – was completed. Subsequent phases, including site visits to selected States for further examination of relevant policies and practices, will be completed by the end of FY 2003.

OMH co-funded a comprehensive study of HHS data collection systems and practices relating to race and ethnicity data. The study was mandated by Title III of the "Minority Health and Disparities Research Education Act," which directed the Secretary to contract with the National Academy of Sciences to conduct a study and develop a report. The study was completed in FY 2002. OMH will be central to the dissemination of findings and identifying opportunities for the implementation of recommendations. Also, in FY 2002, the Office of Minority Health completed a study to develop and test a uniform information/data set (UDS) for evaluating and assessing the impacts of OMH-funded activities. In addition, a journal article on the UDS project were published in FY 2002.

OPHS continued in FY 2002 to foster service demonstration projects, evaluations, and other studies of interventions aimed at improving health and the health care system to strengthen and expand the science base for decision-making, determine model approaches and best practices, and identify and overcome barriers to health, as well as program and intervention effectiveness.

In August 2000, OMH awarded a 17-month contract to the Institute of Medicine for a study entitled *Understanding and Eliminating Racial and Ethnic Disparities in Health Care*. This study was mandated by Congress in FY 2000 appropriations report language to "assess the extent of differences in the kinds and quality of health care received by US racial and ethnic minorities and non-minorities, explore factors that may contribute to differences, and recommend policies and practices that eliminate inequities." The results of this study were released in March 2002.

As a response to the 1999 Institute of Medicine's report, *To Err is Human: Building a Safer Health System*, and its follow-up report, *Crossing the Quality Chasm*, OMH is proposing in FY 2003 to support a study of the impact of cultural and linguistic barriers on patient safety and

medical errors. This study would investigate the interface between health care quality assurance efforts relative to patient safety/medical errors reduction and the challenges posed by cultural and linguistic factors to effective physician/health plan staff-patient interactions, clinical/staff encounters, and diagnosis and treatment options. Included in this study would be a focus on how such barriers affect physician, staff, and member/patient comprehension and member/patient compliance with care and treatment regimens.

By the end of FY 2003, OMH is expected to complete its study of culturally and linguistically appropriate services (CLAS) provided by managed care organizations (MCOs) serving racially/ethnically diverse and vulnerable populations. In FY 2002, OMH developed an instrument to assess the nature and extent of CLAS in local public health agencies (LPHAs) that was modeled after the tool used in the MCO study. The LPHA tool was pilot-tested and will be distributed as part of the final report for the project by the end of FY 2003. Any LPHAs and other agencies so interested will then be able to use the tool for self-assessment purposes as they deem fit. In addition, in FY 2002, OMH initiated and completed a project to assess the feasibility of, and develop a plan for, conducting a study of the nature and extent of CLAS *from the perspective of the consumers/patients served* in targeted delivery settings or communities across the country. Issues of study design, sampling, survey instrument/questionnaire design, cultural and linguistic appropriateness in the conduct of the survey (readability, translation or interpretation requirements), focus testing, time frames, budgets, etc. were considered and weighed. Deliverables included a literature review/scan of related research and technical design issues, and key informant interviews with technical experts within and outside the Federal government; a study design report describing three options at varying funding levels, with strengths and limitations (or pros and cons) fully discussed for each option and recommendations for the best option to use keeping a balance between study integrity, cost, complexity, and time; and a complete evaluation plan/design for the recommended option for conducting the study, including tasks, deliverables, time frames, and cost estimates. Cross-site market area case studies were recommended as the preferred study option.

OMH has continued to support its principal demonstration grant programs. The Office funded 11 continuations and nine new projects under the *Bilingual/Bicultural Service Demonstration Program* to improve the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health services to limited-English-proficient minority populations. It also funded six continuations under the *Minority Community Health Coalition Demonstration Program*, which supports projects that address socio-cultural barriers and demonstrate effective coordination of integrated community-based screening, outreach, and other enabling services. A competitive cycle for this program, renamed the *Community Programs to Improve Minority Health Grant Program*, was conducted in FY 2001 with 17 new awards made which will receive funding through FY 2003.

In FY 2001, OMH established the *Health Disparities Grants in Minority Health Program*. The Program supports local pilot and small-scale projects, which address a wide range of health problems and issues related to health disparities in local minority communities. In FY 2002,

OMH expanded this program from the 30 awards made in FY 2001 to 40.

OMH has also continued the programs funded by the Minority HIV/AIDS Initiative. These include the *Technical Assistance/Capacity Development Demonstration Program (TA/CD) for HIV/AIDS-Related Services in Highly Impacted Minority Communities*, the *State and Territorial Minority HIV/AIDS Demonstration Program*, and the *Minority Community Health Coalition Demonstration Program HIV/AIDS*. More than 60 organizations are involved in these partnerships. OMH conducted competitive cycles in FY 2002 for the *Technical Assistance/Capacity Development Demonstration Program (TA/CD) for HIV/AIDS-Related Services in Highly Impacted Minority Communities*, and the *Minority Community Health Coalition Demonstration Program HIV/AIDS*.

OPHS continues to affect policies, programs and practices to address health disparities. OMH established an effective mechanism for coordinating the various departmental minority initiatives through the Departmental Minority Initiatives Coordinating Committee (DMICC) which the DASMH chairs. The DMICC serves as the coordinating body for the HBCU Initiative, the Hispanic Agenda for Action, the Tribal Colleges and Universities Initiative, and the AAPJ Initiative. In addition, as part of our efforts to streamline the minority initiatives, OMH entered into a contract to develop a template for developing a uniform five-year departmental plan and annual performance report for all four minority initiatives.

OMH has also continued to produce high quality and highly sought after publications that appeal to consumers, universities, State offices of minority health, health educators, researchers, and administrators. During the past two years, OMH produced more than a dozen issues of *Closing the Gap*, a newsletter available both electronically through the Office of Minority Health Resource Center (OMH-RC) web site and in print. Popular issues included *Cultural Competency* and *Oral Health*. In addition, as part of the Congressional Black Caucus (CBC) Initiative, OMH launched *HIV Impact*, a quarterly publication of *Closing the Gap*, which addresses HIV/AIDS-related topics as they affect minority populations.

In addition, OPHS is currently planning the first of three "National Leadership Summits" for eliminating racial and ethnic disparities in health to take place over the current decade. The purpose of these summits is to serve as vehicles for highlighting, promoting, and applying the knowledge, experience, and expertise of hundreds of community-based organizations and partners across the Nation towards more strategic, concerted, and effective actions aimed at eliminating racial and ethnic disparities in health.

Also in response to the State Minority Health Infrastructure Study, OMH convened a National American Indian/Alaska Native Health Forum in September 2002 in Denver, Colorado. Over 300 participants came together for the purpose of identifying strategies through which State, tribal, and Federal governments can complement and supplement their respective health systems to improve the health of Native Americans, including those who are not Federally recognized, and to identify strategies for the development of a coordinated plan for the elimination of health

disparities impacting American Indian/Alaska Native communities.

OMH continued to expand the capability of the Congressionally-mandated Minority Health Resource Center (OMH-RC) to develop information and technical assistance services dedicated to minority health-related HIV/AIDS issues. OMH-RC's HIV/AIDS services team worked to increase awareness of HIV/AIDS among minorities and support organizations that serve minorities. At the end of FY 2002, OMH convened ten regional skills-building meetings for community-based organizations and trained 175 community representatives through these venues. Another 27 organizations received on-site technical assistance and 81 organizations received technical assistance by phone, fax, and e-mail. A total of 7000 client contacts were made for technical assistance purposes.

OMH-RC also houses the Minority Reviewers Database, developed by OHAP/OPHS to make representatives of community-based organizations who have been trained in reviewing grant proposals more widely available to Federal agencies conducting HIV grant reviews. Information and outreach specialists can be reached by telephone toll free at 1-800-444-6472 or by e-mail at info@omhrc.gov. The monthly newsletter, *Closing the Gap* and the quarterly *HIV Impact* have more than 40,000 subscribers. Furthermore, in February 2000, OMH launched a website dedicated to the Department's Minority HIV/AIDS Initiative. This web site provides information on current news, funding, technical assistance, prevention and living with HIV/AIDS, and includes links to reports, archives, and both Federal and non-Federal sites. Web pages for the Minority HIV/AIDS Initiative are projected to draw more than 300,000 hits during FY 2002.

OMH has continued to establish and strengthen networks, coalitions, and partnerships to identify and solve health problems and concerns affecting racial and ethnic minorities. Under the *State Partnership Initiative*, designed to assist State minority health entities in developing or expanding their existing infrastructure and capacity to address racial and ethnic health disparities, OMH awarded contracts to 12 State minority health entities in FY 2000. In FY 2002, as part of this initiative, OMH is continuing support for ten projects that demonstrate best practices and innovative ways to address health disparities at the State and local levels. In 2003, OMH hopes to include projects to help improve State public health entities' ability and capacity for communicating and working with various racial and ethnic minority community organizations to develop and communicate disaster and emergency preparedness plans. Funding for 15 new projects is planned.

In November 2001, OPHS in collaboration with OASPA, initiated a new partnership with the ABC Radio Networks and ABC Radio's Urban Advantage Network to inform minority communities on ways to achieve better health and close the health gaps between them and the rest of the US population. This partnership aims to inform and educate African Americans about the health gap and empower individuals to adopt healthier lifestyles through a health information and education campaign entitled "Closing the Health Gap: Reducing Health Disparities Affecting African Americans." To date, detailed health messages are airing in 10-, 30-, and 60-

second public service announcements on 240 radio stations across the US. In addition, another major component of this campaign, announced by the Secretary in April 2002, was "Take a Loved One to the Doctor Day," which was held on September 24, 2002 and was designed to encourage all Americans, especially minorities to become more involved in their health care. "Take a Loved One to the Doctor Day" included more than 400 national, State, local and community based partners. Over 200 communities in 47 States, DE, and Puerto Rico convened health activities on that day.

Performance Measures

Performance Measures	Targets	Actual Performance
3.0 Collect and establish baseline and comparison data for all measures under this goal and relevant racial and ethnic groups for which no data are currently available. (To establish interim targets, staff will determine the difference between the current baseline and the 2010 target and propose a 10% improvement in the disparity per year. At least current levels will be maintained for any group(s) already at or better than the target.)	FY02: 11 of 11 FY01: 11 of 11 FY00: 11 of 11 FY99: 11 of 11	FY02: 10/04 FY01: 10/03 FY00: 7 of 11 FY99: 5 of 11

Data Source: Healthy People

Performance Measure	Race/Ethnicity	Targets					Baseline/Actual Performance				
		2003	2002	2001	2000		2001	2000	1999	1998	
3.1 Infant mortality rate per 1,000 live births HP2010 Objective 16-1c HP2010 target is 4.5	Whites	5.34	5.46	5.58	5.71	0.8	11.7	06/03	5.7	5.8	6.0
	Blacks						1	13.5	14.0	13.8	
	Hispanics						2	5.7	5.7	5.8	
	AI/ANs						.	8.3	9.3	9.3	
	APIs						6	4.9	4.8	5.5	
							1				
							3				
							.				
							5				
		5.34	5.46	5.58	5.7	7.16	7.54	7.92			
		8.3									
		4.78	4.82	4.86	4.9						
3.2 Mammogram within past 2 years (women 40+) HP2010 Objective 3-13 HP2010 target is 70%	White women	71.71	71.71					03/03	71%	71%	67%
	Black women	68.6	68.4	68.2	68			68%	71%	66%	
	Hispanic women	65.1	64.4	63.7	63			63%	66%	61%	
	AI/AN women	57.4	55.6	53.8	52			52%	63%	45%	
	API women	60.9	59.6	58.3	57.0			57%	59%	61%	
3.3 Pap test within past 3 years (women 18+)	White women	84.4	83.6	82.8	82.0			03/03	82%	81%	79%
	Black women	85.8	85.2	84.6	84.0			84%	84%	83%	

DM GPRA Performance Plans

Performance Measure	Race/Ethnicity	Targets				Baseline/Actual Performance			
		2003	2002	2001	2000	2001	2000	1999	1998
HP2010 Objective 3-11b HP2010 target is 90%	Hispanic women AI/AN women API women	80.9 80.9 73.9	79.6 79.6 71.6		78.3 77.0 69.3	77.0		77% 90% 66%	74% 72% 67%
3.4 Coronary heart disease death rates (age- adjusted) HP2010 Objective 12-1 HP2010 target is 166	White Black Hispanic AI/AN API	186 208.32 138.41 124 Not Set	188.8 3214.3 138.4 124 Not Set	191.7 220.4 138.4 Not Set	194.5 226.4 115 Not Set			07/03 243 135 124 115	193 226.4 138.4 DSU DSU
3.5 Stroke death rates (age-adjusted) HP2010 Objective 12-7 HP2010 target is 48	White Black Hispanic AI/AN API	55.7 71.8 3939 4040 Set	56.8 75.2 3939 Not Set Not Set	57.9 82 3939 Not Set Not Set	59 82 51.5 52 Not			07/03 82 39 40 53	59 82.4 40 DSU DSU
3.6 Rate of lower extremity amputations in persons with diabetes (per 1,000 diabetic patients) HP 2010 Objective 5.10 HP2010 target is 1.8	Whites Blacks Hispanics AI/ANs APIs	2.92 Not Set Not Set Not Set Not Set	3.08 Not Set Not Set Not Set Not Set	3.15 Not Set Not Set Not Set Not Set	3.3 Not Set Not Set Not Set Not Set			06/04 7.3 DSU DSU DSU	06/03 3.4 DSU DSU DSU
3.7 New cases (per 1,000,000) of end-stage renal disease HP2010 Objective 4-7 HP2010 target is 78	Whites Blacks Hispanics AI/ANs APIs	100.41 320.23 225.72 378.34 153.61	103.6 2354.8 7246.8 3421.2 6164.4	106.8 389.4 267.9 464.1 175.2	110 424 289 507 186			10/03 424 289 507 186	110 315.6 161.1 334.5 128.8
3.8 Incidence of diagnosed AIDS cases among adolescents and adults (per 100,000) HP 2010 Objective 13.1 HP2010 target is 1	White males Black males Hispanic males AI/AN males API males White females Black females Hispanic females AI/AN females API females	10.1 75.2 33.3 12.4 5.3 1.84 32.4 9.96 2.61 1.49	11.4 85.8 37.9 14 5.96 1.96 36.9 11.24 2.84 1.56	12.7 96.4 42.6 17.3 7.2 2.08 41.4 12.52 3.07 1.63	14.0 107 47.2 14.5 7.8 2.2 45.9 13.8 3.3 1.7			07/03 107 47.2 17.3 7.2 07/03 45.9 13.8 3.3 1.7	14 124.8 54.4 18 7.6 2.2 49 14.9 5.0 1.4
3.9 HIV mortality rate	White males Black males Hispanic males AI/AN males API males	3.71 236.2 8.26 Not Set Not Set	4.14 269.8 9.34 Not Set Not Set	4.57 303.5 10.42 Not Set Not Set	5.0 337.1 11.5 Not Set Not Set			07/03 337.1 11.5 DSU DSU	01/03 5.0 10.7 4.0 1.4

DM GPRA Performance Plans

Performance Measure	Race/Ethnicity	Targets				Baseline/Actual Performance			
		2003	2002	2001	2000	2001	2000	1999	1998
HP Objective 13-14 HP2010 target is 0.7	White females	91.94	.97	1.0		07/03	03/03	1.0	.8
	Black females	9.59	10.86	12.13	13.4	13.4	12.2		
	Hispanic females	2.38	2.622	.86	3.1	3.1	2.8		
	AI/AN females	Not Set	Not Set	Not Set	Not Set	DSU	DSU		
	API females	Not Set	Not Set	Not Set	Not Set	DSU	DSU		
3.10 Child immunization** coverage									
DPT 4 doses HP 2010 Obj. 14-22a HP2010 target is 90%	White	85.885	2 84.6	84.0		84.0	84.0	85.5	86.6
	Black	80.278	.8 77.4	76.0		77.0	76.0	79.0	77.3
	Hispanic	82.381	2 80.1	79.0		83.0	79.0	80.2	80.5
	AI/AN	79.578	.0 76.5	75.0		77.0	75.0	80.2	82.9
	API	86.586	.0 85.5	85.0		DNA	85.0	86.8	89.1
HIB 3 doses HP 2010 Obj. 14-22b HP2010 target is 90%	White	95 95	95 95			94 95	94.8	95	
	Black	93 93	93 93			89 93	91.8	90.1	
	Hispanic	91 91	91	91		92 91	92.0	91.7	
	AI/AN	90 90	90 90			93 90	91.4	90.0	
	API	92 92	92 92			DNA	92	90.2	92.3
MMR 1 dose HP 2010 Obj. 14-22d HP2010 target is 90%	White	92 92	92 92			92 92	92.4	93.3	
	Black	88.6	88.4	88.2	88	89 88	89.8	88.9	
	Hispanic	90 90	90 90			92 90	90.2	91.2	
	AI/AN	88.9	87.6	87.3	87	93 87	91.7	91.4	
	API	90 90	90 90			DNA	90	92.7	92.4
Hepatitis B 3 doses HP 2010 Obj. 14-22c HP2010 target is 90%	White	91 91	91 91			90 91	88.9	88.3	
	Black	89.3	89.2	89.1	89	85 89	86.5	83.7	
	Hispanic	88.688	.4 88.2	88		90 88	87.3	85.7	
	AI/AN	91 91		91	91	87 91	DSU	81.6	
	API	91 91	91 91			DNA	91	88.2	89.0
Varicella 1 dose HP 2010 Obj. 14-22f HP2010 target is 90%	White	73.2	70.8	68.4	66	75 66	56.0	41.9	
	Black	73.9	71.6	69.3	67	76 67	57.6	42.4	
	Hispanic	76 74	72 70			80 70	60.5	46.9	
	AI/AN	70.4	67.6	64.8	62	69 62	DSU	28.0	
	API	80.9	79.6	78.3	77	82 77	64.0	52.6	
Polio 3 doses HP 2010 Obj. 14-22e HP2010 target is 90%	White	91 91	91 91			90 91	90.3	92.2	
	Black	87.9	87.6	87.3	87	85 87	87.0	87.8	
	Hispanic	88.6	88.4	88.2	88	91 88	89.4	88.9	
	AI/AN	90 90	90	90		88 90	88.2	85.1	
	API	93 93	93 93			DNA	93	90.1	93.4
3.11 Adult immunization coverage									

DM GPRA Performance Plans

Performance Measure	Race/Ethnicity	Targets				Baseline/Actual Performance			
		2003	2002	2001	2000	2001	2000	1999	1998
<u>Non-institutionalized adults 65+</u>									
Influenza	White	73.270.8	68.4	66		06/03 66	68%	65%	
HP 2010 Obj. 14-29a	Black	60.656.4	52.2	48		48	51%	46%	
HP target is 90%	Hispanic	66.262.8	59.4	56		56	56%	51%	
	AI/AN	Not Set	Not Set	Not Set	Not Set	DSU	DSU	DSU	
	API	69.066.0	63.0	60.0		60	71%	68%	
Pneumococcal	White	66.262.8	59.4	56		06/03 56	53%	48%	
HP 2010 Obj. 14-29b	Black	48.7	42.8	36.9	31	31	33%	26%	
HP2010 target is 90%	Hispanic	48.7	42.8	36.9	31	31	29%	23%	
	AI/AN	Not Set	Not Set	Not Set	Not Set	DSU	DSU	DSU	
	API	57.152.4	47.7	43		43	40%	36%	
<u>Non-institutionalized high-risk adults 18-64</u>									
Influenza	White	38.335.2	32.1	29		02/03	29%	28%	27%
HP 2010 Obj. 14-29c	Black	35.532.0	28.5	25		25%	25%	23%	
HP 2010 target is 60%	Hispanic	35.532.0	28.5	25		25%	27%	24%	
	AI/AN	41.839.2	36.6	34		34%	28%	29%	
	API	37.634.4	31.2	28		28%	23%	30%	
Pneumococcal	White	29.224.8	20.4	16		02/03	16%	14%	13%
HP 2010 Obj. 14-29d	Black	28.524.0	19.5	15		15%	16%	14%	
HP2010 target is 60%	Hispanic	25.020.0	15.0	10		10%	8%	11%	
	AI/AN	37.634.4	31.2	28		DSU	28%	25%	
	API	Not Set	Not Set	Not Set	Not Set	DSU	DSU	DSU	
<u>Institutionalized adults</u>									
Influenza	White	73.2	70.8	68.4	66	02/05	02/04	66%	DNC
HP 2010 Obj. 14-29e	Black	71.8	69.2	66.6	64	64%	DNC		
HP 2010 target is 90%	Hispanic	72.5	70.0	67.5	65.0	65%	DNC		
	AI/AN	Not Set	Not Set	Not Set	Not Set	DSU	DNC		
	API	Not Set	Not Set	Not Set	Not Set	DSU	DNC		
Pneumococcal	White	54.3	49.2	44.1	39	02/05	02/04	39%	DNC
HP 2020 Obj. 14-29f	Black	48	42	36	30	30%	DNC		
HP2010 target is 90%	Hispanic	52.9	47.6	42.3	37	37%	DNC		
	AI/AN	Not Set	Not Set	Not Set	Not Set	DSU	DNC		
	API	Not Set	Not Set	Not Set	Not Set	DSU	DNC		

DSU = Data statistically unreliable; DNC = Data not collected.

Part III: Appendix to OPHS FY 2004 Performance Plan**Appendix 1. Linkage to HHS Strategic Plan**

Selected HHS Strategic Priorities and Objectives	OPHS Priority	Contributing OPHS Offices
Preventing Disease and Illness	Strengthening Prevention	National Vaccine Program Office, Office of Disease Prevention and Health Promotion, Office of HIV/AIDS Policy, Office of Minority Health, Office of Population Affairs, Office of the Surgeon General, Office on Women's Health, President's Council on Physical Fitness and Sports
Closing Gaps in Health Care	Closing Health Gaps	Office of Minority Health, Office on Women's Health, Office of Disease Prevention and Health Promotion, Office of HIV/AIDS Policy, Office of Population Affairs, Office of the Surgeon General
Improving Health Science; Protecting our Homeland; Realizing the Possibilities of 21 st Century Health Care	Strengthening the Public Health Infrastructure, including the research enterprise and data collection	National Vaccine Program Office, Office for Human Research Protection, Office of HIV/AIDS Policy, Office of Research Integrity, Office of the Surgeon General, Office of Military Liaison and Veterans Affairs, Office of Disease Prevention and Health Promotion, Office of Minority Health, Office on Women's Health

Appendix 2. Changes and Improvements Over Previous Year

Changes are presented in Part II, Program Performance Analysis. There were no changes to goals between the Final FY 2003 Plan and the Revised Final FY 2003 Plan.

Appendix 3. Partnerships and Coordination

OPHS values collaboration and works in partnership with other HHS components, as well as a variety of other Federal agencies (including the Departments of Education, Justice, Labor, Agriculture, Defense, State, Transportation, Commerce, Energy, Housing and Urban Development, and Veterans Affairs; the Environmental Protection Agency; the Federal Emergency Management Agency; and the US Consumer Product Safety Commission), tribal,

State and local governments, health departments and agencies, the academic community, health providers, national professional associations, tribal, national and international health-related organizations, community-based organizations, minority community-based organizations, faith-based institutions, the media, advocacy groups, the business community, foundations, the public, Congress, and others. Through its program offices, OPHS has established close ties with stakeholders who are critical to addressing significant public health and science issues in the Nation and around the world.

See the sections in each priority area on "Promote Effective Partnerships" and "Lead and Coordinate Key Initiatives Within and on Behalf of the Department."

Appendix 4. Data Verification and Validation

New Plan

Shape Policy at the Local, State, National, and International Level: OPHS will assess the changes in policies and programs in targeted entities with which it works that can be attributable to specific OPHS leadership, such as the number of States and communities that adopt "Healthy People 2010" plans modeled on the national initiative. Records of the assessments will be maintained by individual OPHS offices and summarized for OPHS GPRA reporting.

Communicate Strategically: OPHS will track the level of Website visitors, clearinghouse inquiries, and workshops and conferences designed to disseminate public health knowledge; it will track the number of new, targeted educational materials and campaigns; and it will track media coverage of specific OPHS initiatives or events.

Promote Effective Partnerships: OPHS will track the number of governmental and non-governmental organizations that change their agendas and programs due to specific interagency agreements or Memoranda of Understanding with OPHS.

Strengthen the Science Base: OPHS will track the number of its scientific peer reviewed texts that are printed by GPO or in professional journals and the number of findings from research, demonstration, or evaluation studies that are disseminated. It will also record specific data enhancements that are attributable to OPHS leadership, such as the reduction in "developmental" objectives in Healthy People 2010 (i.e. objectives that did not have baseline data when the report was published in 2000) or the reduction in data cells for racial, ethnic, and other select population groups for which data were either not collected or not analyzed. Because OPHS does not fund these data systems, such improvements must be achieved indirectly.

Lead and Coordinate Key Initiatives Within and on Behalf of the Department: OPHS offices will track the number of key initiatives that it convenes, coordinates, and/or chairs and, as a subset, the number of those initiatives that result in unique, substantive outcomes.

Old Plan

Most performance measures in this plan were selected from among the nationally-recognized health objectives of *Healthy People* the state-of-the-art for consensus on population-based health status outcomes. *Healthy People* objectives contain ambitious decade-long targets. OPHS based its performance measures for FYs 1999 and 2000 on objectives from *Healthy People 2000* (launched in 1990 with health targets for the year 2000), and performance measures for FY 2001, 2002, and 2003 on *Healthy People 2010* (final edition released November 2000 with health targets for the year 2010).

For the purposes of this performance report, OPHS has selected targets consistent with *Healthy People 2010*, the nation's health agenda for the first decade of the twenty-first century. It contains two goals, 467 objectives, and 28 focus areas. Each year, the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention publishes the most recent data on progress towards the *Healthy People* targets. The data produced by NCHS are compiled from State and local public agencies, Federal surveys and other data sources. The data are used for a wide variety of purposes by Federal, State and local officials; researchers; legislators; the media; the public; and others.

OPHS proposes to use the most recently published NCHS data as its primary source for performance measurement whenever possible. For performance measures that are not included in *Healthy People*, and therefore not monitored by NCHS, other data sources have been identified. OPHS's use of NCHS data provides many benefits. For example, the data have been subjected to intense review and are regarded as the "gold-standard" for health information. Without NCHS data, OPHS could not include health outcomes – of the utmost importance to Congress and the American public – as performance measures. In addition, OPHS will not need to invest significant resources in the development of monitoring systems for its performance measures. These factors are consistent with Congress's intent for GPRA. One problematic aspect of relying on NCHS data is that there will be a lag in reporting on the performance measures. For the measures based on mortality or death rates, the lag time will be 1 to 2 years; for measures based on behaviors and morbidity, the lag time is likely to be 2 to 3 years. On balance, OPHS considers the strengths of the data to outweigh the weaknesses.

For those performance measures based on *Healthy People 2010* objectives, whenever more recent and more complete baseline or actual performance data are available from the *Data 2010* database (<http://wonder.cdc.gov/data2010/obj.htm>), such data are now used in the performance plan and report. If more recent and more complete baseline or actual performance data are not available from Data 2010, then data are obtained from the specific data source for the objective in question (e.g., National Vital Statistics System, HIV/AIDS Surveillance System).

Appendix 5. Performance Measurement Linkages

Performance Goal: Communicate strategically. OPHS is assessing its Internet activities to identify opportunities for cost savings in Web site support contracts.

OPHS uses evaluation set-aside funds to review key programs that contribute to one or more performance goals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

<u>FY 2004 Budget</u>	<u>Page</u>
Appropriation Language and Analysis	290
Amounts Available for Obligation	292
Summary of Changes	293
Budget Authority by Activity	294
Budget Authority by Object	295
Salaries and Expenses	297
Authorizing Legislation	299
Appropriations History Table	300
Justifications:	
General Statement	302
Assistant Secretary for Public Health Emergency Preparedness	305
Cyber-Security	312
Medical Reserve Corps	316
Pandemic Flu	319

APPROPRIATION LANGUAGE AND ANALYSIS

For expenses necessary to support activities related to countering potential biological, disease and chemical threats to civilian populations, [\$2,295,184,000] \$1,896,149,000, of which \$100,000,000 shall be for activities to ensure a year-round influenza vaccine production capacity and the development and implementation of rapidly expandable production technologies: Provided, That the Secretary of Health and Human Services may increase funding for such pandemic influenza activities by transfer of up to \$150,000,000 from available unobligated amounts in discretionary accounts (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended) of the Department of Health and Human Services funded in this or prior appropriations Acts: Provided further, That funding for pandemic influenza activities shall remain available until expended. [Department of Health and Human Services Appropriation Act, 2002, as enacted by Title II of PL 107-116.]

LANGUAGE ANALYSIS

Language Provision

"\$100,000,000 shall be for activities to ensure a year-round influenza vaccine production capacity and the development and implementation of rapidly expandable production technologies: Provided, That the Secretary of Health and Human Services may increase funding for such pandemic influenza activities by transfer of up to \$150,000,000 from available unobligated amounts in discretionary accounts (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended) of the Department of Health and Human Services funded in this or prior appropriations Acts; Provided further, That funding for pandemic influenza activities shall remain available until expended"

Explanation

Provides funding for the planning and implementation of preparatory activities of influenza vaccine production.

AMOUNTS AVAILABLE FOR OBLIGATION

	FY 2002 <u>Actual</u>	FY 2003 President's <u>Budget</u>	FY 2004 <u>Estimate</u>
Annual appropriation	\$2,887,263,000	\$2,291,984,000	\$1,896,149,000
Rescission pursuant to PL 107-206	<u>-1,396,000</u>	<u>-</u>	<u>-</u>
Subtotal	2,885,867,000	2,291,984,000	1,896,149,000
Real transfer to:			
Department of Homeland Security	<u>-1,216,453,000</u>	<u>-485,804,000</u>	<u>-</u>
Subtotal	1,669,414,000	1,806,180,000	1,896,149,000
Comparable transfers to:			
CDC, for Health Facilities Construction and Management Fund, for facilities construction and security	-46,000,000	-	-
NIH, for research and laboratory construction and security	<u>-180,000,000</u>	<u>-</u>	<u>-</u>
Subtotal	1,443,414,000	1,806,180,000	1,896,149,000
Comparable transfer from:			
HRSA, for Poison Control/Emergency Medical Services for Children	<u>+43,683,000</u>	<u>-</u>	<u>-</u>
Subtotal, adjusted budget authority	\$1,487,097,000	\$1,806,180,000	\$1,896,149,000
Unobligated balance (carry-over funds available for obligation)	-99,484,060	285,918,710	-
Real transfer to:			
Social Security Administration ¹	<u>-532,859</u>	<u>-482,459</u>	<u>-</u>
Total obligations	\$1,587,113,919	\$2,092,581,169	\$1,896,149,000

¹ Funds available to the Social Security Administration by virtue of the Determination Order; their unexpended balance at the time of their departure from HHS on March 31, 1995.

SUMMARY OF CHANGES

FY 2003 Request (adjusted)	\$1,806,180,000
Total estimated budget authority	1,806,180,000
 FY 2004 Request	 \$1,896,149,000
Total estimated budget authority	1,896,149,000
 Net change	 +\$89,969,000

	<u>FY 2003 Base</u>	<u>Change from Base</u>
	<u>Budget</u>	<u>Budget</u>
	<u>(FTE)</u>	<u>(FTE)</u>
	<u>Authority</u>	<u>Authority</u>
<u>Increases:</u>		
Pandemic Flu	\$-	+\$100,000,000
<u>Decreases:</u>		
HRSA:		
Information Technology savings	618,204,000	-31,000
SAMHSA:		
Mental health program	10,000,000	<u>-10,000,000</u>
 Total decreases		 -10,031,000
 Net Change		 +\$89,969,000

BUDGET AUTHORITY BY ACTIVITY
(Dollars in thousands)

	FY 2002		FY 2003		FY 2004	
	<u>Actual</u>		<u>President's Budget</u>		<u>Estimate</u>	
	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>
Bioterrorism	45	1,487,097	82	\$1,806,180	89	\$1,796,149
Pandemic Flu	-	-	-	-	-	100,000

BUDGET AUTHORITY BY OBJECT

	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Full-time equivalent employment ¹	82	89	+7
Average SES salary	\$133,800	\$136,476	+2,676
Average GS grade	14.5	14.5	-
Average GS salary	\$91,450	\$93,279	+\$1,829
Personnel compensation:			
Full-time permanent	\$21,596,000	\$22,653,000	+\$1,057,000
Other than full-time permanent	2,271,000	2,271,000	-
Other personnel compensation	<u>2,022,000</u>	<u>2,022,000</u>	-
Subtotal, personnel compensation	25,889,000	26,946,000	+1,057,000
Civilian personnel benefits	11,254,000	11,483,000	+229,000
Benefits to former personnel	-	-	-
Subtotal, pay costs	37,143,000	38,429,000	+1,286,000
Travel	3,492,000	3,492,000	-
Transportation of things	30,000	30,000	-
Rental payments to GSA	6,132,000	6,132,000	-
Rental payments to others	179,000	179,000	-
Communications, utilities, miscellaneous charges	3,492,000	3,492,000	-
Printing and reproduction	453,000	453,000	-
Other contractual services:			
Advisory and assistance services	29,385,000	28,099,000	-1,286,000
Other services	30,396,000	30,365,000	-31,000
Purchases of goods and services from Government accounts	45,854,000	45,854,000	-
Operation and maintenance of facilities	55,043,000	55,043,000	-
Research and development contracts	51,242,000	151,242,000	+100,000,000
Medical care	-	-	-

Public Health and Social Services Emergency Fund

	FY 2003 President's <u>Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Operation and maintenance of equipment	\$1,467,000	\$1,467,000	<u>\$-</u>
Subsistence for Persons	<u>29,000</u>	<u>29,000</u>	<u>-</u>
Subtotal, other contractual services ...	213,387,000	312,070,000	+98,683,000
Supplies and materials	83,345,000	83,345,000	-
Equipment	16,122,000	16,122,000	-
Land	17,990,000	17,990,000	-
Grants, subsidies and contributions ...	<u>1,424,386,000</u>	<u>1,414,386,000</u>	<u>-10,000,000</u>
Subtotal, non-pay costs	1,769,037,000	1,857,720,000	+88,683,000
 Total budget authority	 \$1,806,180,000	 \$1,896,149,000	 +\$89,969,000

SALARIES AND EXPENSES
(Budget Authority)

	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Personnel compensation:			
Full-time permanent (11.1)	\$21,596,000	\$22,653,000	+\$1,057,000
Other than full-time permanent (11.3)	2,271,000	2,271,000	-
Other personnel compensation (11.5)	<u>2,022,000</u>	<u>2,022,000</u>	<u>-</u>
Subtotal, personnel compensation (11.9)	25,889,000	26,946,000	+1,057,000
Civilian personnel benefits (12.1)	11,254,000	11,483,000	+229,000
Benefits to former personnel (13.0)	<u>-</u>	<u>-</u>	<u>-</u>
Subtotal, pay costs	37,143,000	38,429,000	+1,286,000
Travel (21.0)	3,492,000	3,492,000	-
Transportation of things (22.0)	30,000	30,000	-
Rental payments to others (23.2)	179,000	179,000	-
Communications, utilities, and miscellaneous charges (23.3)	3,492,000	3,492,000	-
Printing and reproduction (24.0)	453,000	453,000	-
Other contractual services:			
Advisory and assistance services (25.1)	29,385,000	28,099,000	-1,286,000
Other services (25.2)	30,396,000	30,365,000	-31,000
Purchases of goods and services from Government accounts (25.3)	45,854,000	45,854,000	-
Operation and maintenance of facilities (25.4)	55,043,000	55,043,000	-
Research and development contracts (25.5)	51,242,000	151,242,000	+100,000,000
Medical care (25.6)	-	-	-

Public Health and Social Services Emergency Fund

	FY 2003 <u>Pres Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Operation and maintenance of equipment (25.7)	\$1,467,000	\$1,467,000	\$—
Subsistence for Persons	<u>29,000</u>	<u>29,000</u>	<u>—</u>
Subtotal, other contractual services	213,387,000	312,070,000	+98,683,000
Supplies and materials (26.0)	<u>83,345,000</u>	<u>83,345,000</u>	<u>—</u>
Total, Salaries and Expenses	\$341,550,000	\$441,519,000	+\$100,000,000

AUTHORIZING LEGISLATION

	2003 Amount <u>Authorized</u>	2003 Pres Budget <u>Pres Budget</u>	2003 Amount <u>Authorized</u>	2004 Budget <u>Budget Request</u>
Public Health Security and Bioterrorism Preparedness and Response Act of 2002	—	\$1,806,180,000	—	\$1,896,149,000

APPROPRIATIONS HISTORY TABLE
(Non-Comparable)

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
<u>FY 1995</u>				
Appropriation	-	-	-	-
<u>FY 1996</u>				
Appropriation	-	-	-	\$900,000,000
Rescission				-13,000
<u>FY 1997</u>				
Supplemental Appropriation	-	-	-	15,000,000
<u>FY 1998</u>				
Appropriation	-	-	-	-
<u>FY 1999</u>				
Appropriation	-	-	-	216,922,000
Y2K Appropriation				189,053,000
<u>FY 2000</u>				
Appropriation	386,022,000	391,800,000	475,000,000	583,600,000
Rescission				-437,000
<u>FY 2001</u>				
Appropriation	264,600,000	286,600,000	264,600,000	241,231,000
Rescission				-282,000
Supplemental Appropriation	-	-	-	126,150,000
<u>FY 2002</u>				
Appropriation (Labor/HHS/Ed)	250,619,000	300,619,000	250,619,000	242,949,000
(Defense)	-	-	-	2,644,314,000
Rescission				-1,396,000

Public Health and Social Services Emergency Fund

	Budget Estimate <u>to Congress</u>	House <u>Allowance</u>	Senate <u>Allowance</u>	<u>Appropriation</u>
<u>FY 2003</u> Request	\$1,806,180,000			
<u>FY 2004</u> Request	1,896,149,000			

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

	FY 2002	FY 2003	FY 2004	Increase or
	<u>Actual</u>	<u>President's Budget</u>	<u>Estimate</u>	<u>Decrease</u>
Budget Authority	\$1,487,097,000	\$1,806,180,000	\$1,896,149,000	+\$89,969,000
FTE	45	82	89	+7

GENERAL STATEMENT

The events of September 11, 2001, and the anthrax attacks that followed brought many unforeseen and unprecedented challenges to the American people. The public health and medical response was a defining moment in history, as HHS deployed hundreds of health personnel from around the nation and activated the National Pharmaceutical Stockpile to conduct over 140 missions throughout the fall of 2001. In addition, for the first time in its history, the National Disaster Medical System (NDMS) was activated 12 times in less than a year to respond to acts of bioterrorism. The HHS Bioterrorism Program, which had been established in 1999 to prepare for the rare possibility of domestic terrorism, responded at a level consistent with the President's designation of HHS as the lead agency for bioterrorism preparedness.

In addition to this recognition by the President, the Department's standing as a major contributor to US security with respect to the health and medical consequences of terrorism was formalized by Congress, with the passage of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. In addition to providing legislative authorities for the Department's ongoing preparedness and response activities, this Act created the Office of the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP) to direct and coordinate the efforts of the Department to bolster State and local emergency preparedness.

The goal of the HHS Bioterrorism Program is to ensure sustained public health and medical readiness for our communities and our nation against a biological agent attack or epidemic disease. The objectives of the HHS Bioterrorism Program are as follows:

- To develop the critical public health infrastructure and core capacities necessary to ensure that communities and States can detect and control infectious disease outbreaks that may be terrorist-induced or naturally occurring.
- To enhance capacities at a National level for epidemic detection and control, pharmaceutical and vaccine development and acquisition, and laboratory expertise and security.

- To ensure, in collaboration with the Department of Homeland Security, an adequate pharmaceutical stockpile to support the medical and public health response to a bioterrorism incident or naturally occurring epidemic of infectious disease.
- To participate in appropriate international and national initiatives that may assist in preventing or deterring the release of a biological weapon and/or mitigating the public health consequences of such a release.
- To educate the public health and medical workforce for bioterrorism preparedness and response.
- To ensure that community and regional health care systems are prepared for the medical and psychological needs of victims of bioterrorism and other public health emergencies.
- To develop an effective risk communication and information dissemination strategy for the public.
- To promote a national bioscience research and development effort related to civilian biodefense.
- To coordinate medical and public health preparedness with other emergency preparedness efforts at the community, State, and Federal level.
- To support the efforts of other agencies and organizations (e.g., Department of Justice, Department of Homeland Security) charged with first responder preparedness and other types of terrorism response.
- To support the efforts of the Office of Homeland Security by providing health and medical leadership.

HHS is committed to building the necessary infrastructure and developing the requisite resources through the efforts of CDC, the Office of the Secretary (OS), NIH, FDA, and HRSA. For FY 2004, HHS proposes an investment of \$3,596,504,000 to continue the Department's Bioterrorism Program: \$1,796,149,000 in the Public Health and Social Services Emergency Fund (PHSSEF), and \$1,800,533,000 in the direct appropriations of NIH and FDA (please see the following chart).

FY 2004 BIOTERRORISM FUNDING SOURCES

<u>OPDIV</u>	<u>PHSSEF</u>	<u>Direct Appropriations</u>	<u>TOTAL</u>
CDC	\$1,116,156,000	-	\$1,116,156,000
HRSA	618,173,000	-	618,173,000
OS	61,820,000	-	61,820,000
NIH	-	1,624,536,000	1,624,536,000
FDA	-	<u>175,819,000</u>	<u>175,819,000</u>
Total	\$1,796,149,000	\$1,800,355,000	\$3,596,504,000

The FY 2004 request for the OS portion of the PHSSEF is \$61,820,000. These funds will provide the needed resources to support OS activities for a more comprehensive program to: prepare for the health and medical consequences of bioterrorism and other public health emergencies; and continue the Department's cyber-security efforts.

The budget justification that follows represents funds requested within OS, the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP), the Assistant Secretary for Budget, Technology and Finance (ASBTF), and the Office of the Surgeon General (OSG) within the Office of Public Health and Science (OPHS). Funding for CDC and HRSA are also included in the PHSSEF; however, the justifications for these requests are found in those agencies' individual budget submissions.

ASSISTANT SECRETARY FOR PUBLIC HEALTH EMERGENCY PREPAREDNESS

	FY 2002 <u>Enacted</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$48,775,000	\$41,820,000	\$41,820,000	—
FTE	45	80	87	+7

Purpose and Method of Operations

The Office of the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP) was established to direct the Department's efforts in preparing for, protecting against, responding to, and recovering from acts of bioterrorism and other public health emergencies that affect the civilian population. ASPHEP serves as the focal point within HHS for these activities, directing and coordinating the development and implementation of a comprehensive HHS strategy. To carry out this strategy, ASPHEP performs the following functions:

- Leadership for HHS Bioterrorism activities: The HHS bioterrorism effort requires the diverse and unique skills of scientists, public health experts and health care providers at NIH, CDC, FDA, HRSA and SAMHSA. ASPHEP focuses the activities of these agencies, provides program oversight and is the Secretary's public health emergency representative to other Federal, State and local organizations. This leadership has been demonstrated in ASPHEP's direction of HHS resources to carry out the President's commitment that a smallpox vaccination is available for every US citizen.
- Direction and Coordination of State and Local Preparedness Funding: Within a four-month period over the past year, under the leadership of ASPHEP, the Department designed a program and awarded and released approximately \$1.1 billion to 50 States, 4 major cities and the American territories. ASPHEP organized a process that enabled the review and approval of approximately 120 State workplans within 30 working days. The primary result of this process was a coordinated national approach to public health emergency preparedness consistent between public health departments and hospitals, the key service providers that will be needed in a bioterrorism event.
- Vaccine and Pharmaceutical Research and Development: ASPHEP's Advanced Research program provides oversight and supervision to vaccine production contracts managed by CDC and research efforts carried out by NIH and FDA. ASPHEP will provide continuing direction and guidance on the development of new vaccines and therapeutics that can be used against smallpox, anthrax and other potential agents of

bioterrorism.

- Global Infectious Disease Outbreak Control. ASPHEP has led planning meetings regarding international disease surveillance with infectious disease specialists from CDC and the military, international organizations (WHO and PAHO), private foundations with an expressed special interest in this area (Nuclear Threat Initiative and Lilly Foundation), and university-based specialists in efforts to build a coherent interlocking set of systems that will be able to detect the unusual, determine its implications, characterize the causative agents in the laboratory, and, thus, guide both immediate epidemiological response and enhanced preparedness for similar future events.
- Direction of all HHS Public Health Emergency Resources: Through the Secretary's Command Center (SCC) and the Secretary's Emergency Response Team (SERT), and Field Preparedness Officers (FPO), HHS has the capacity to provide advance assessment of public health emergencies to all HHS resources at CDC, FDA, NIH and HRSA. ASPHEP has been designated by the Secretary to lead the HHS response to public health emergencies. In a bioterrorist event, or other public health emergency, the SCC, the SERT and the FPO's function as the Secretary's command assets with the goal of ensuring that HHS resources are used to their fullest to prevent the loss of life during a public health emergency, including a bioterrorist event.
- Emergency Planning and Response Coordination: HHS serves as the Lead Federal Agency to plan for and respond to the health consequences of terrorist incidents involving weapons of mass destruction. Working with the Department of Homeland Security (DHS), HHS will carry out its role as the lead Department for Emergency Support Function (ESF) #8 under the Federal Response Plan (FRP). ASPHEP is the action agent for all activations of ESF 8 and independent authorities under which HHS responds to public health emergencies through the Public Health Service Act, as amended, 42 U.S.C., Section 319 & 311.
- Continuity of Operations (COOP) / Continuity of Government (COG): In 1998, the White House issued Executive Order 12656 requiring "The head of each Federal department and agency shall ensure the continuity of essential functions in any national security emergency by providing for: succession to office and emergency delegation of authority in accordance with applicable law; safekeeping of essential resources, facilities and records; and establishment of emergency operating capabilities." ASPHEP has lead responsibility for ensuring that HHS complies with all COOP/COG requirements including the planning and implementation of Departmental functions during emergencies.

The FY 2004 budget request will allow ASPHEP to carry out the following major goals and objectives:

- State and Local Preparedness: ASPHEP, working with CDC and HRSA, will coordinate the third year of the cooperative agreement program that integrates preparedness activities among State and local health departments and with hospitals. Continued support of this function will ensure the following:
 - Interaction between State/local public health departments and hospitals with respect to infectious disease surveillance.
 - Epidemiological investigations launched by the State health departments with inclusion of, or participation by, appropriate experts from hospitals in the affected area(s).
 - Continued support for hospital-based laboratories becoming part of the Laboratory Response Network, which has been established by CDC to create a multi-level, broad-based laboratory system to provide testing capabilities for all biological agents.
 - Integration of electronic information and communications systems that are being developed at the State and local level to link health departments, hospitals and other major health providers, especially in times of health emergencies. Without this vital linkage, health advisories, disease reporting, surveillance data, laboratory results and other information will not be rapidly shared among all pertinent parties, thus delaying speedy responses by appropriate health officials.
 - The training of public health workers and their hospital/healthcare counterparts will be consistent and coordinated.
- Vaccine and Pharmaceutical Research and Development: ASPHEP's Advanced Research program provides oversight and supervision to vaccine production contracts managed by CDC and research efforts carried out by NIH and FDA. Additionally, this program, with its partners, will expand the knowledge base in FY 2004 relevant to planning and evaluating the mass casualty care component of the CDC- and HRSA-funded cooperative agreements with States. ASPHEP also will partner with academic institutions to develop training and create test-beds where this issue can be addressed. Specific projects include:
 - Phase I vaccine studies for Ebola, Anthrax rPA and 2 strains for 3rd generation smallpox vaccines.
 - Joint projects between the National Institute of Allergies and Infectious Diseases (NIAID) and the United States Army Medical Research Institute for Infectious Diseases (USAMRIID) to conduct testing and development of high-priority products, such as therapeutics and vaccines for anthrax and plague.

- NIAID's development of a hybrid vaccine candidate that protects mice from West Nile virus (WNV) infection. Researchers are testing the WNV vaccine candidate in monkeys and may begin human trials in FY 2003.
- The Department's on-going development of therapeutic technologies, including vaccines and anti-virals, that could be used in the event of a influenza pandemic.
- Advanced development and exploration of model systems to rectify the unique set of problems associated with providing surge capacity for contagious and non-contagious agents in existing hospital facilities.
- Establishing emergency hospital services in places such as gymnasiums and motels.
- Investigating the potential use of Veterans Administration and DOD hospitals to enhance community-based, mass-casualty care.
- Developing systems for delivering the unique needs relating to the provision of pediatric care in emergency settings.

• **Preparedness Planning and Response Coordination:** Through the SERT, SCC, field preparedness operations, exercises and training, ASPHEP will continue to lead the HHS public health emergency preparedness function. The FY 2004 budget request will continue the development of the following assets and activities:

- Secretary's Emergency Response Team. Comprised of technical experts rapidly deployed to determine the nature and scope of public health threats and emergencies, the SERT will consult with and support State and local public health authorities, assess the need for Federal public health assistance; and make recommendations to the Secretary regarding deployment of resources; keep the Secretary informed during public health threats and emergencies and participate in post-event evaluation and continuing development of HHS bioterrorism resources.
- The Secretary's Command Center. The base of communications and information for HHS during a public health emergency is the Secretary's Command Center (SCC), which has 24/7 operational staffing including watch officers and communications technicians; satellite phone, radio and systems for both CONUS and international communications, and T1 connectivity to operational sites for connectivity through "trusted lines" that provide both voice and data sharing between HHS agencies and to other Federal partners.
- Emergency Support Function 8. HHS serves as the Lead Federal Agency to plan

for and respond to the medical health consequences of terrorist incidents involving weapons of mass destruction. Working with DHS and other Federal agencies, ASPHEP will direct and coordinate the HHS support for the Federal Response Plan (FRP) through health assessments, deployments of the Commissioned Corp Readiness Force (CCRF) for medical care; radiological, chemical, biological hazards consultation; mental health care, vector control and other public health services. ASPHEP is the lead for all HHS participation in Federal interagency training activities including the upcoming TOPOFF 2003 exercise.

- **Field Preparedness Operations.** In coordination with State and local health departments, ASPHEP's field preparedness operations serves as the HHS point of contact on the ground during the immediate aftermath of a public health emergency; provides supports for all health and medical assets pre-deployed for special events in the field (Olympic Games, Papal visits, etc.,) and works with other Federal field offices including the FBI on terrorism task forces and other interagency emergency committees.
- **Continuity of Operations (COOP)/Continuity of Government (COG).** Within HHS, the responsibility for defining and developing COG and COOP programs has been delegated to the Assistant Secretary for Public Health and Emergency Preparedness. This responsibility includes the establishment of alternative mechanisms for carrying out HHS functions should the existing, primary assets become inoperable; regular exercise to evaluate the readiness of these alternative mechanisms, and the ongoing maintenance including equipment upgrades and service agreements for all systems established under COOP/COG including communications, transportation and facilities.

Rationale for the Budget Request

The FY 2004 estimate for the Public Health and Social Services Emergency Fund for ASPHEP is \$41,820,000, the same level as the FY 2003 President's Budget request. Funds are requested for the following activities:

- **Operations (\$12,720,000)** – These funds will support ASPHEP's leadership for all HHS bioterrorism activities, including the direction and coordination of State and local preparedness funding, the Secretary's Advisory Council on Public Health Preparedness, and field preparedness operations for public health emergencies. Funds are used for staff salaries, rent, utilities, and consultant support to augment the in-house effort. Also included is funding for travel, training, logistics support, audit services, conferences, and other management-related activities.
- **Advanced Research (\$5,000,000).** These funds will support ASPHEP's oversight and

supervision of vaccine contracts at CDC and research efforts at NIH and FDA. Funds also are used to expand the knowledge base relevant to planning and evaluating the mass casualty care components of the CDC and HRSA funded cooperative agreement with States. Areas of emphasis included advanced development of model systems to rectify the unique set of problems associated with providing surge capacity for contagious and non-contagious agents in existing hospital facilities and developing systems for delivering care to meet the unique needs of children in emergency settings.

- **International Early Warning Surveillance (\$9,500,000)** – These funds will support disease surveillance systems in developing countries from which has come AIDS, Ebola and Marburg virus epidemics, Congo-Crimean hemorrhagic fever and other viruses. Some of these agents, if weaponized, could cause extraordinary havoc as biologic weapons. Likewise of interest and concern is the possibility that terrorists might experiment with chemical agents (as the Aum Shinrikyo did with Sarin) or an agent might escape from a bioweapons production facility (as happened with anthrax at Sverdlovsk). Epidemiological and laboratory capacity in the countries would enhance the ability to prevent disease from spreading to the US. Funds also would support international public health preparedness education through fellowship training both in epidemiology and in diagnostic methods to begin to strengthen what is an all too limited cadre of expertise and working relationships with relevant institutions in other countries.
- **Secretary's Emergency Response Team (\$3,000,000)** – These funds will support the operations of HHS technical experts rapidly deployed to determine the nature and scope of public health threats and emergencies. The SERT consults with and supports State and local public health authorities, assesses the need for Federal public health assistance; and make recommendations to the Secretary regarding deployment of resources. The SERT is the "eyes and ears" of the Secretary and keeps HHS leadership informed during public health threats and emergencies. Funds also will support the 24/7 operations of the Secretary's Command Center (SCC), which serves as the base of communications and information for the Secretary during a public health emergency.
- **Media/Public Information Campaign (\$4,800,000)** – These funds will continue to support a vigorous effort proposed in the FY 2003 President's Budget to enhance public health risk communication. Media plays an important role in terrorism by modulating the community's response to a terrorist attack and, thereby, either furthering or thwarting the terrorist's intent. Television, radio, and newspapers can cover catastrophic events like terrorism in a manner that fosters individual and community recovery by disseminating accurate information and dispelling rumors, educating the public on normal responses to trauma and disasters, and providing information on available resources. ASPHEP has begun to establish a public advisory committee on Emergency Public Information and Communications (EPIC) as authorized in the Public Health Security and Bioterrorism Preparedness and Response Act. Funds requested will be used to implement recommendations from the EPIC committee, and to carry out this initiative

as proposed.

- **Preparedness Planning and Evaluation (\$6,800,000)** – These funds will support planning of emergency response coordination, including the exercise and training of HHS preparedness assets internally and with its interagency partners. A primary function of this budget activity is the development, implementation and maintenance of the HHS Continuity of Operations (COOP)/ Continuity of Governance (COG) plans. Funds also will be used for the continued leadership of HHS for health and medical consequence management under Emergency Support Function 8 (ESF 8) of the Federal Response Plan (FRP). This includes participation in Federal interagency training activities such as the upcoming TOPOFF 2003 exercise.

CYBER-SECURITY

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$5,000,000	\$10,000,000	\$10,000,000	-
FTE	-	-	-	-

Purpose and Method of Operations

The Office of Information Resources Management (OIRM), under the Assistant Secretary for Budget, Technology and Finance (ASBTF), is responsible for ensuring the security of the Department's systems and assets that are used to disburse billions of dollars through Medicare and Medicaid, critical social services such as Head Start, childcare and child support enforcement, a life-giving organ transplant system, food and pharmaceutical quality, groundbreaking biomedical research, accurate and timely disease treatment information and the detection of disease outbreaks and bioterrorism.

Information technology (IT) security and critical infrastructure protection (CIP) are essential components underlying HHS's mission – namely, the stewardship of our information resources and the preservation of our trust and credibility.

The HHS IT Security Program focuses on the protection of critical assets – information systems data – so that the people using the systems can depend on the electronic environment being reliable, available, accurate, and authorized. The IT Cyber-Security projects aim to prevent, detect, and respond to security events. Critical Infrastructure Protection ensures that those IT assets, systems, and services that are essential to the conduct of critical business functions are safeguarded from disruption, failures, and compromise.

Our HHS strategic plan for IT security identifies specific goals, performance measures, and supporting projects to focus HHS' efforts and investments for advancing HHS' security and continuity of critical service programs. Our plan identifies and prioritizes to achieve measurable outcomes in support of the IT security vision. The core of this IT security plan focuses on the Security Program, which is designed to achieve the following aims:

- Ensure compliance with US Code and Federal legislation;
- Ensure a robust enterprise security program at HHS;
- Ensure compliance with HHS security policies, procedures, and practices;

- Ensure common standards and practices; and
- Ensure that new or potential security vulnerabilities are swiftly identified and addressed.

Clear benefits of an effective HHS IT security program are the successful mitigation or prevention of the following:

- Adverse impact on public health practices due to corruption of medical data;
- Loss of critical services that can adversely affect health and safety of the public;
- Unauthorized or illegal disclosure of confidential, private, or other sensitive information regarding individuals, medical records, proprietary data, intellectual property, etc;
- Loss of irreplaceable scientific research data;
- Financial fraud and other computer crime;
- Breach of confidential business data such as assurances of contractual requirements and agreements with business partners;
- Loss of access to health and welfare information by the public, researchers, policy makers, healthcare professionals and others;
- Loss of trust resulting from compromised content or corruption of information for use by the public, researchers, policy makers, healthcare professionals and others;
- Economic consequences of addressing security breaches such as clean-up efforts, shutting down computers, systems, and networks during clean-up and validation, restoration costs of systems and data, lost productivity, litigation, etc.; and
- Damage to the credibility, reputation, image, and public trust of HHS and its OPDIVs.

In FY 2002, with \$5,000,000 in Cyber-Security funds, OIRM was able to:

- Substantially progress in review and validation of HHS Project Matrix Step 1 findings, to insure that all CIP assets are correctly identified, given changes in perspective resulting from 9/11/01.
- Complete the Project Matrix Step 2 Process for three CIP assets and solidly progress in the Project Matrix Step 2 Process for fifteen other CIP IT assets. During the performance of Project Matrix Step 2 the interdependencies of a particular CIP asset with other HHS IT assets are identified.

- Substantially progress in the security certification and accreditation for the top 15 CIP Cyber Assets, to ensure that all necessary security risks have been remediated, and documentation is complete and current.
- Provide oversight and assistance to complete the GISRA corrective actions for the top fifteen CIP Cyber Assets, to improve the security position of the Department relative to these assets.

In FY 2003, OIRM's plans are to:

- Initiate the Project Matrix Step 2 process for all remaining CIP Cyber Assets, to identify interdependencies with other HHS IT assets.
- Perform Certification and Accreditation for the all remaining CIP Cyber Assets, to ensure that all necessary security risks have been remediated, and that documentation is complete and current.
- Provide oversight and assistance to complete the GISRA/FISMA corrective actions for the all remaining CIP Cyber Assets, to improve the security position of the Department relative to these assets.
- Develop and refine a robust Department-level centralized IT security oversight and compliance assurance function within the Office of the HHS Chief Information Officer.

Rationale for the Budget Request

The \$10,000,000 requested for Cyber-Security in FY 2004 will be used to:

- Initiate the Project Matrix Phase Step 2 and 3 Processes for CIP assets identified as a result of HHS efforts to defend against bioterrorism.
- Initiate the Project Matrix Phase 3 Process for all CIP Assets, to determine weaknesses, risks, and vulnerabilities resulting from interfacing with public sector systems.
- Establish an annual security program to provide penetration testing and vulnerability scanning for all CIP and CIP related Assets.
- Establish a robust Department-level centralized Computer Security Incident Response Capability or Security Operations Center (SOC).
- Provide continuous assistance to complete FISMA corrective actions for all CIP Assets.
- Provide continuous security monitoring for all HHS system, assets, and services.

- Implement, empower, and institutionalize a Department-level centralized security oversight and compliance assurance function within the Office of the HHS Chief Information Officer.

MEDICAL RESERVE CORPS

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$3,000,000	\$10,000,000	\$10,000,000	+\$—
FTE	—	2	2	—

Purpose and Method of Operations

In his January 2002 State of the Union address, the President announced the creation of the USA Freedom Corps, including the Citizen Corps. In March 2002, the Office of the Surgeon General was assigned responsibility for carrying forward, on behalf of the Department, the Federal-level development of the Medical Reserve Corps (MRC), part of the Citizen Corps.

The MRC is the Citizen Corps component that is organizing local volunteers to assist regular medical response professionals and facilities during a large-scale local emergency (e.g., influenza epidemic or hazardous materials spill). Health professionals (current, retired or otherwise-employed) and others with relevant skills are being offered the opportunity to volunteer their time and skills within a planned, organized and coordinated local MRC unit during times of emergency. MRC volunteers can also serve a vital role by assisting their communities with ongoing public health needs (e.g., immunizations, health and nutrition education, and volunteering in community health centers and local hospitals).

Citizen Corps Councils and/or an appropriate local-government recognized entity, which has responsibility for developing and/or implementing a community-based MRC unit, is eligible to apply for a grant under the MRC demonstration project. To be recognized as a Citizen Corps Council, the entity must be registered with the Citizen Corps, USA Freedom Corps. Citizen Corps Councils may be established in any county, city or other recognized locality in the US and its territories.

Since March 2002, the following has been accomplished:

- Developed the document "*Medical Reserve Corps - Guide for Local Leaders*" which includes an Appendix with valuable references.
- Established an MRC website to support local MRC units, and develop an MRC logo.
- Implemented a small-grants program to help jump-start local MRC units; a total of more than \$2 million and 42 grants were awarded in September 2002, to 27 States and six Citizen Corps Council Communities.

- Developed a technical assistance contract to provide valuable expert technical assistance to the newly implemented local MRC units.
- Held consultation meetings with numerous organizations.

In FY 2003, it is anticipated that:

- Approximately \$8,000,000 will be provided to award 200 grants.
- To the extent that funds permit, technical assistance will be provided to registered Citizen Corps Councils and/or designated MRC planning groups, subject to their formally requesting assistance to establish an MRC unit.
- By the end of 2003, almost 250 MRC units will be under development and technical assistance will have been provided to more than 300 groups. Communication on MRC will have reached all 50 States, 100 non-governmental organizations, 2,500 communities, and 100,000 individuals.

Rationale for the Budget Request

The FY 2004 request for the Medical Reserve Corps is \$10,000,000, the same as requested in the FY 2003 President's Budget. This level will allow the MRC initiative to maintain the same level of activity as in FY 2003.

The objective of the MRC program is to establish as many MRC units as possible across the nation. A goal is to have a local MRC unit for all small cities and rural counties as well as large metropolitan areas. With the average size grant being approximately \$40,000, 200 grants totaling \$8 million can be awarded in FY 2004. The remainder of the funds will be used for technical support.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

Office of the Secretary
(Dollars in Thousands)

	FY 2002 <u>Enacted</u>	FY 2003 President's <u>Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Assistant Secretary for Public Health Emergency Preparedness				
Operations	\$12,531	\$12,720	\$12,720	—
Advanced Research	4,644	5,000	5,000	—
International Early Warning Surveillance ..	9,500	9,500	9,500	—
Secretary's Emergency Response Team	3,000	3,000	3,000	—
Media/Public Information Campaign	—	4,800	4,800	—
Preparedness Planning and Evaluation	6,300	6,800	6,800	—
Command, Control & Communications	<u>13,000</u>	—	—	—
<i>Subtotal, ASPHEP</i>	<i>48,975</i>	<i>41,820</i>	<i>41,820</i>	—
Assistant Secretary for Budget, Technology and Finance				
Cyber-Security	5,000	10,000	10,000	—
Office of the Surgeon General				
Medical Reserve Corps	<u>3,000</u>	<u>10,000</u>	<u>10,000</u>	—
Total, OS	\$56,975	\$61,820	\$61,820	—

PANDEMIC FLU

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Budget Authority	\$-	\$-	\$100,000,000	+\$100,000,000
FTE	-	-	-	-

Purpose and Method of Operations:

The influenza strains circulating worldwide usually change somewhat from year to year. Periodically, there is a major change in the virus's genetic structure, resulting from a strain that can cause widespread disease and death. Three such global epidemics – called pandemics – occurred in the 20th Century. Such a pandemic could cause an additional 90,000 to 300,000+ deaths in the US, especially if adequate vaccine were not available quickly. The ever-changing nature of the influenza virus makes the natural emergence of a pandemic strain not only possible, but inevitable.

Pandemic influenza represents both a naturally-occurring and potentially man-made threat to our Nation's health. The influenza pandemic of 1918 claimed more than 25 million lives globally (and more than 500,000 in the United States) in less than 10 months. During a two-week period in October 1918 alone, at least 7,100 people in Philadelphia died from influenza and influenza-associated pneumonia. The genome for the 1918 virus has been largely sequenced, and it is theoretically possible to re-create this virus using readily available technology. In fact, unique strains of the influenza virus have been created in the laboratory entirely from cloned DNA using reverse genetics.

Most scientists in the field agree that it is not a question of *whether* there will be another influenza pandemic, but rather *when* it will occur. Once a pandemic begins, it will be too late to accomplish the many key activities required to minimize its toll. Vaccines cannot be prepared in advance and stockpiled, but planning and implementation of preparatory activities can – indeed, must – start well in advance.

Rationale for the Budget Request

Currently, the Nation's influenza vaccine supply totals about 90 million doses. In the 2003-2004 influenza season, the US will rely upon only two suppliers of licensed influenza vaccine. Preparing for a severe pandemic could require more than 280 million doses of vaccine, with no more than four or five months available for manufacturing.

The FY 2004 request for pandemic influenza preparedness is a new effort totaling \$100,000,000. This increase will be used to develop a targeted and responsive strategy to respond to pandemic influenza, whether as a natural threat or as an agent of bioterrorism.

Examples of the preparatory activities that these funds will be used for in advance of an actual flu pandemic include:

- Developing a year-round domestic influenza vaccine production capacity. This might involve contracts with industry to maintain an egg supply in the off season.
- Developing production techniques that could be scaled up rapidly (i.e., providing surge capacity) in the event of a pandemic. This could include incentives to develop and license a cell culture influenza vaccine and agreements on surge production for US use in a pandemic.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**PROPOSED GENERAL PROVISIONS
FOR FISCAL YEAR 2004**

The President's Budget recommends several general provisions be included in the FY 2004 Departments of Labor, Health and Human Services and Education Appropriations Act. These provisions follow appendix schedules for the Department of Health and Human Services (Title II General Provisions) and the Departments of Labor, Health and Human Services and Education (Title V General Provisions). The following is a summary of the proposed provisions:

Title II

Sec. 201. This provision proposes an appropriation of up to \$50,000 for official reception and representation expenses which must be specifically approved by the Secretary.

Sec. 202. This provision enables the Secretary to assign not more than 60 Public Health employees to assist in child survival activities and to work with AIDS through programs with the Agency for International Development, the United Nation's International Children's Emergency funds and the World Health Organization.

Sec. 203. This provision provides that no funds appropriated under this Act be used in the implementation of section 399F(b) of the Public Health Service Act or section 1503 of the National Institutes of Health Revitalization Act of 1993, Public Law 103-43.

Sec. 204. This provision proposes to limit, to a maximum of Executive Level II per year, the rate at which the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration may pay an individual when using a grant or extramural funding appropriated under this title.

Sec. 205. This provision proposes to allow the Secretary to use not more than 1.25% of any appropriations authorized under the PHS Act for the evaluation of the implementation and effectiveness of the PHS programs.

Sec. 206. This provision proposes to authorize the Secretary to transfer up to 3 percent of discretionary funds with a limitation that no single account could be increased by greater than 10% between appropriations for the Department of Health and Human Services in this, or any other Act (e.g., Agriculture and Rural Development Act, Interior Act, and Labor, Health and Human Services, Education, and Related Agencies Act). Appropriations Committees in both Houses of Congress are to be notified at least 15 days in advance of any transfer.

Sec. 207. This provision proposes that the Director of the National Institutes of Health, jointly

with the Director of the Office of AIDS Research, may transfer up to 3 percent among institutes, centers and divisions from the total amounts identified by these two Directors as funding for research pertaining to the human immunodeficiency virus.

Sec. 208. This section provides that the amount for research related to the human immunodeficiency virus at the National Institutes of Health, as jointly determined by the Director of the National Institutes of Health and the Director of the Office of AIDS Research, will be available to the Office of AIDS Research account as necessary to carry out section 2353(d)(3) of the Public Health Service Act.

Sec. 209. This section provides that none of the funds appropriated in this Act may be available to any entity under title X of the Public Health Service Act unless the award applicant certifies to the Secretary that it encourages family participation in family planning services for minors and provides counseling to minors on how to resist coercion into engaging in sexual activities.

Sec. 210. This section provides that none of the funds appropriated by this Act, including trust funds, may be used to carry out the Medicare+Choice program if the Secretary denies an entity participation in the program based on the information that the entity will not provide, pay for, or provide referrals for abortions.

Sec. 211. This provision proposes that no provider of services under title X of the Public Health Service Act be exempt from State laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape or incest.

Sec. 212. This section provides that none of the funds appropriated by this Act can be used to withhold substance abuse funding from a State, if the State certifies to the Secretary of Health and Human Services by May 1, 2004 that it will commit additional State funds to ensure compliance with State laws prohibiting the sale of tobacco products to individuals under 18 years of age. The State is to submit a report to the Secretary on all fiscal year 2003 State expenditures and all fiscal year 2004 obligations for tobacco prevention and compliance activities.

Sec. 213. This provision provides authority to support CDC in carrying out international HIV/AIDS and other infectious and chronic disease activities abroad during fiscal year 2004.

Sec. 214. This section provides that the Division of Federal Occupational Health may utilize personal services contracting to employ professional management/administrative and occupational health professionals.

Sec. 215. This section provides that funds appropriated to the National Institutes of Health in this Act, which are available for grants or contracts, may be obligated in fiscal year 2002 for the full multi-year cost of grants and contracts that are awarded in that year, and such obligated funds shall remain available until expended.

Title V

Sec. 501. This provision proposes that the Secretaries of Labor, Health and Human Services, and Education be authorized to transfer unexpended balances of prior appropriations to accounts corresponding to those included in this Act as long as the balances are used for the same purpose and the same period of time they were originally appropriated.

Sec. 502. This provision proposes that no appropriation contained in this Act remain available for obligation for a period beyond the current fiscal year unless it is expressly stated in this Act.

Sec. 503. This provision proposes that:

(a) Except for normal and recognized executive-legislative relationships, no part of any appropriation in this Act shall be used for publicity or propaganda, preparation, distribution, publication, radio or TV broadcast or film presentation designed to support or defeat legislation pending before Congress, except as a presentation to Congress itself.

(b) No part of any appropriation in this Act be used to pay the salary or expenses of any grant or contract recipient (or their agent) related to activities designed to influence legislation or appropriations pending before the Congress or any State legislature.

Sec. 504. This provision applies only to the Secretaries of Labor and Education and the Director of the Federal Mediation and Conciliation Service.

Sec. 505. This provision proposes that no funds appropriated under this Act may be used to carry out a program of distributing sterile needles for the hypodermic injection of any illegal drug.

Sec. 506. This provision proposes that:

(a) To the greatest extent practicable, all equipment and products purchased with funds made available under this Act should be American-made.

(b) The head of each Federal agency, to the greatest extent practicable, provide a notice describing the statement in subsection (a) when providing financial assistance to or entering into a contract with any entity using the funds made available under this Act.

(c) Any person found to have falsely labeled products as "Made in America" be ineligible to receive any contract or subcontract made with funds available under this Act.

Sec. 507. This provision proposes that all Federal grantees (including State and local governments and recipients of Federal research grants) issuing press releases, requests for proposals and other documents describing projects or proposals supplied with Federal funds

clearly state the following: 1) the percentage of total costs of the program or project financed with Federal money; 2) the dollar amount of Federal funds for the project or program; and 3) the percentage and dollar amount of the total cost to be financed by non-governmental sources.

Sec. 508. This provision provides that none of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated under this Act:

- (a) may be expended for abortion;
- (b) may be expended for health benefits coverage that includes coverage of abortion.

The term 'health benefits coverage' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

Sec. 509. The limitations established in the preceding section shall not apply to an abortion:

- (a) if the pregnancy is the result of an act of rape or incest; or
- (b) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless the abortion is performed.
- (c) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's Medicaid matching funds). Further, nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

Sec. 510. This provision proposes that none of the funds made available in this Act may be used for creation of a human embryo, embryos for research, or research in which a human embryo or embryos is destroyed. For the purposes of this section, human embryos include any organism derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

Sec. 511. This provision provides that none of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or controlled substance except when (1) there is significant medical evidence of therapeutic advantage to the use of such drug or other substance or (2) Federally-sponsored clinical trials are being conducted to determine therapeutic advantage.

Sec. 512. This section provides that none of the funds made available in this Act may be used to enter a contract with a contractor with the US Government who is subject to section 4212(d) of

title 38, United States Code, but has not submitted the most recent annual report, required by that section, to the Secretary of Labor detailing the employment of certain veterans.

Sec. 513. This section provides that none of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act providing for, or providing for the assignment of, a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR

2004

Program Support Center

*Justification of
Estimates for
Appropriations Committees*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

HHS Service and Supply Fund Overview 3

Program Support Center 5

Retirement Pay and Medical Benefits 49

Government Performance and Results Act 63

OVERVIEW – HHS SERVICE AND SUPPLY FUND

The HHS Service and Supply Fund is a revolving fund authorized under 42 USC 231. The Fund provides for consolidated financing and accounting for operations involving the provision of common services and commodities to customer agencies. The SSF includes 2 components: the Program Support Center (PSC), including the Federal Occupational Health (FOH) franchise fund, which was previously part of Health Resources Service Administration; and Office of the Secretary (OS) administrative services. The PSC has 6 major services: Human Resources Service, Commissioned Personnel Services, Financial Management Service, Administrative Operations Service and the Office of Information Resource Management. The FOH provides health-related services that include the Employee Assistance Program, Occupational Health, and Environmental Health. The OS services include two systems, the Departmental Contract Information System and Tracking Accountability in Government Grants System, as well as other activities that either comply with legislative mandates or provide services to the Office of the Secretary.

The SSF does not receive appropriated resources, but is funded entirely through charging HHS agencies, as well as other Federal agencies and departments, for usage of goods and services. The FY 2003 and FY 2004 estimated budgets are \$456 million (1,193 FTE) and \$466 million (1,193 FTE), respectively.

The SSF is governed by a Board of Directors that holds regularly scheduled quarterly meetings. The Board is chaired by the Deputy Secretary, vice-chaired by the Assistant Secretary for Budget, Technology and Management (ASBTF) and includes representatives from each HHS agency. In addition to representatives from each HHS agency, the Board includes chief management officers of the PSC and an ex-officio (non-voting) representative from the HHS Office of Inspector General. Each member of the Board, except for the OIG member, has one vote when the Board makes decisions. The Board approves the annual SSF budget, approves the rates for services, directs the SSF Fund Manager concerning the overall financial management of the SSF, arranges for management or cost studies, and may make decisions that would change the scope of the Fund Activities.

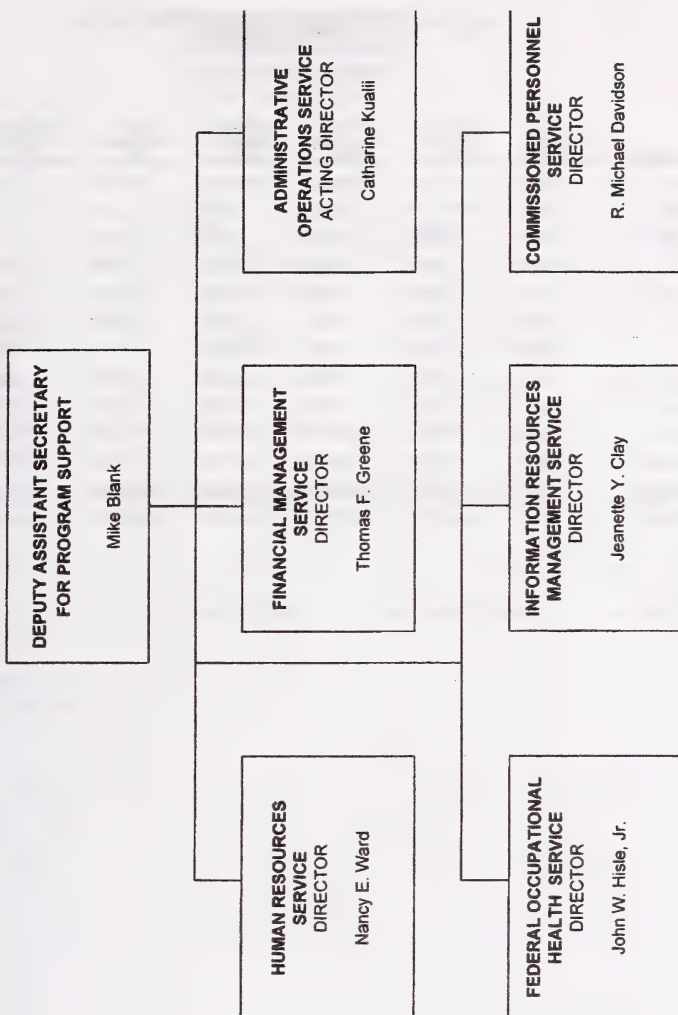
The detailed budget justifications for the Program Support Center and the Retirement Pay and Medical Benefits for Commissioned Officers follow this overview.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER
SERVICE AND SUPPLY FUND

<u>FY 2004 Budget</u>	<u>Page</u>
Organization Chart	6
Revenue by Customer	7
Expenses by Activity	8
Expenses by Object	9
Salaries and Expenses	10
Justification:	
A. Account Summary	11
B. General Statement	12
C. Human Resources Service	18
D. Commissioned Personnel Service	20
E. Financial Management Service	23
F. Administrative Operations Service	29
G. Federal Occupational Health	37
Detail of Full-Time Equivalent Employment	46
Detail of Positions	47

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROGRAM SUPPORT CENTER



DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER
SERVICE AND SUPPLY FUND

FY 2004 Estimated Revenue by Customer

Customer	Human Resources Service	Commissioned Personnel Service	Financial Management Service	Administrative Operations Service	Federal Occupational Health	Office of the Director (FOIA)	Total
ACF	\$3,868,000	\$0	\$8,051,000	\$6,240,000	\$157,000	\$0	\$18,316,000
AOA	328,000	0	538,000	613,000	4,000	0	\$1,483,000
CMS	2,764,000	240,000	3,431,000	79,000	300,000	0	\$6,814,000
OS	9,073,000	235,000	4,218,000	18,211,000	113,000	42,000	\$31,892,000
AHRQ	745,000	38,000	635,000	1,715,000	43,000	42,000	\$3,216,000
CDC	4,855,000	2,367,000	1,192,000	1,308,000	792,000	42,000	\$10,556,000
FDA	7,109,000	1,304,000	397,000	26,932,000	846,000	42,000	\$36,630,000
HRSA	1,236,000	3,322,000	7,183,000	12,275,000	240,000	42,000	\$24,298,000
IHS	8,845,000	5,634,000	7,974,000	8,733,000	722,000	42,000	\$31,950,000
NIH	10,797,000	1,337,000	10,567,000	24,171,000	1,040,000	42,000	\$47,974,000
SAMHSA	1,529,000	268,000	1,382,000	5,787,000	81,000	42,000	\$9,069,000
NON-HHS	456,000	4,208,000	10,196,000	87,791,000	133,605,000	0	\$236,259,000
TOTAL	\$51,605,000	\$18,951,000	\$55,787,000	\$193,855,000	\$137,943,000	\$336,000	\$458,477,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

Expenses by Activity

	FY 2002 Actual		FY 2003 Estimate		FY 2004 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
Human Resources Service.....	264	\$41,017,000	264	\$51,617,000	264	\$51,60
Commissioned Personnel Service	103	17,161,000	103	19,477,000	103	18,95
Medical Management Service.....	243	53,510,000	258	56,702,000	258	55,78
Administrative Operations Service	400	182,339,000	402	191,791,000	402	193,85
Operative Admin. Support Unit	28					
Medical Occupational Health.....	83	119,885,000	93	128,761,000	93	137,94
Office of the Director.....	27	*	28	*	28	*
Department of Information Act.....	3	308,000	3	324,000	3	33
TOTAL.....	1,151	\$414,220,000	1,151	\$448,672,000	1,151	\$458,47

Expenses for the immediate Office of the Director have been
attributed to the five operating services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER
EXPENSES BY OBJECT

	FY 2003 Estimate	FY 2004 Estimate	Increase or Decrease
Full-time equivalent employment.....	1,151	1,151	1,151
Full equivalent of overtime & holiday hours.....	10	10	10
Average SES salary.....	\$137,440	\$141,564	\$4,124
Average GS grade.....	10.71	10.75	0.04
Average GS salary.....	68,474	70,267	1,793
Average CO grade.....	4.45	4.85	0.40
Average CO salary.....	86,255	89,070	2,815
Average Wage Graded grade.....	4.32	4.88	0.56
Average Wage Graded salary.....	33,485	34,391	906
Personnel Compensation:			
Full-Time Permanent (11.1).....	\$68,889,000	\$68,508,000	-381,000
Other than Full-Time Permanent (11.3).....	1,876,000	1,936,000	60,000
Other Personal Compensation (11.5).....	2,225,000	2,296,000	71,000
Military Personnel (11.7).....	7,337,000	7,571,000	234,000
Special Personal Services Payments. (11.8).....	1,448,000	1,494,000	46,000
Subtotal, Personnel Compensation.....	\$1,775,000	\$1,805,000	30,000
Civilian Personnel Benefits (12.1).....	17,301,000	17,165,000	-136,000
Military Personnel Benefits (12.2).....	3,092,000	3,183,000	91,000
Benefits to Former Personnel (13.0).....	376,000	399,000	23,000
Subtotal, Pay Costs	102,544,000	102,552,000	8,000
Travel (21.0).....	2,634,000	2,625,000	-9,000
Transportation of Things (22.0).....	2,444,000	2,531,000	87,000
Rental Payments to GSA (23.1).....	12,359,000	12,712,000	353,000
Communications, Utilities, and			0
Miscellaneous Charges (23.3).....	8,035,000	8,140,000	105,000
Printing and Reproduction (24.0).....	1,451,000	1,502,000	51,000
Other Contractual Services:			
Advisory and Assistance Services (25.1).....	20,140,000	20,871,000	731,000
Other Services (25.2).....	148,155,000	144,309,000	-3,846,000
Purchases from Govt. Accts. (25.3).....	25,964,000	26,907,000	943,000
Operation and Maintenance of Facilities (25.4).....	18,698,000	19,376,000	678,000
Operation and Maintenance of Equipment (25.7).....	9,031,000	9,359,000	328,000
Subtotal, Other Contractual Services.....	221,988,000	220,822,000	-1,166,000
Supplies and Materials (26.0).....	85,764,000	93,870,000	8,106,000
Equipment (31.0).....	11,453,000	13,723,000	2,270,000
Subtotal, Non-Pay Costs.....	346,128,000	355,925,000	9,797,000
Total, Reimbursable Obligations.....	448,672,000	458,477,000	9,805,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER
SALARIES AND EXPENSES

Object Class	FY 2003 Estimate	FY 2004 Estimate	Increase or Decrease
Personnel Compensation:			
Full-Time Permanent (11.1).....	\$68,889,000	\$68,508,000	-381,000
Other than Full-Time Permanent (11.3).....	1,876,000	1,936,000	60,000
Other Personal Compensation (11.5).....	2,225,000	2,296,000	71,000
Military Personnel (11.7).....	7,337,000	7,571,000	234,000
Special Personal Services Payments. (11.8).....	1,448,000	1,494,000	46,000
Subtotal, Personnel Compensation.....	81,775,000	81,806,000	30,000
Civilian Personnel Benefits (12.1).....	17,301,000	17,165,000	-136,000
Military Personnel Benefits (12.2).....	3,092,000	3,183,000	91,000
Benefits to Former Personnel (13.0).....	376,000	399,000	23,000
Subtotal, Pay Costs.....	102,544,000	102,552,000	8,000
Travel (21.0).....	2,634,000	2,625,000	-9,000
Transportation of Things (22.0).....	2,444,000	2,531,000	87,000
Communications, Utilities, and Miscellaneous Charges (23.3).....	8,035,000	8,140,000	105,000
Printing and Reproduction (24.0).....	1,451,000	1,502,000	51,000
Other Contractual Services:			
Advisory and Assistance Services (25.1).....	20,140,000	20,871,000	731,000
Other Services (25.2).....	148,155,000	144,309,000	-3,846,000
Purchases from Govt. Accts. (25.3).....	25,964,000	26,907,000	943,000
Operation and Maintenance of Facilities (25.4).....	18,698,000	19,376,000	678,000
Operation and Maintenance of Equipment (25.7).....	9,031,000	9,359,000	328,000
Subtotal, Other Contractual Services	221,988,000	220,822,000	-1,166,000
Supplies and Materials (26.0).....	85,764,000	93,870,000	8,106,000
Subtotal, Non-Pay Costs	322,316,000	329,490,000	7,174,000
Total, Reimbursable Obligations.....	424,860,000	432,042,000	7,182,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

Account Summary

	FY 2002 Actual	FY 2003 Estimate	FY 2004 Estimate	Increase or Decrease
Expenses.....	\$414,220,000	\$448,672,000	\$458,477,000	\$9,805,000
FTE.....	1,151	1,151	1,151	0
Human Resources Service.....	\$41,017,000	\$51,617,000	\$51,605,000	-\$12,000
Commissioned Personnel Service....	17,161,000	19,477,000	18,951,000	-526,000
Financial Management Service.....	53,510,000	56,702,000	55,787,000	-915,000
Administrative Operations Service....	182,339,000	191,791,000	193,855,000	2,064,000
Federal Occupational Health.....	119,885,000	128,761,000	137,943,000	9,182,000
Office of the Director.....	*	*	*	*
Freedom of Information.....	308,000	324,000	336,000	12,000
TOTAL.....	\$414,220,000	\$448,672,000	\$458,477,000	\$9,805,000

* Expenses for the immediate Office of the Director have been distributed to the five operating services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAM SUPPORT CENTER

General Statement

The Program Support Center was established to provide measurable, qualitative, and cost effective administrative and logistical support services to the Department of Health and Human Services (HHS), other Executive Departments, and independent Federal agencies.

The activities and services of the PSC are supported through the HHS Service and Supply Fund (SSF), a revolving fund, which was established by 42 U.S.C. 231. The Fund provides consolidated financing and accounting for common administrative services and products. The Fund does not receive appropriated resources, but is funded entirely through charging HHS operating and staff divisions, Executive Departments, and other Federal agencies, for their use of services and products.

The past few years has brought both new leadership and strategic direction to the Executive Branch, as well as to the Department. The President's five key government reform initiatives are:

- Budget and Performance Integration
- Strategic Management of Human Capital
- Competitive Sourcing
- Improve Financial Performance, and
- Expanding Electronic Government

In support of these initiatives, the Program Support Center identified four core goals that are illustrative of the outcomes the PSC seeks to achieve. Each of the goals has specific objectives which support and reinforce the President's Management Agenda, the Secretary's "One Department," and the HHS "10 and 10" goals. The core goals are:

Customer Service

Financial Resource Management

Business Strategy and Innovation

Employee Management and Development

By its very nature, the PSC is a performance-driven organization. The budget of the PSC is approved by the HHS Service and Supply Fund Board of Directors which is comprised of senior managers of HHS customer organizations. The PSC prepares its budgets based upon projected business base, and collects revenue based upon actual performance of services and goods. The PSC develops a budget and closely tracks revenues and expenditures in an effort to maintain a break-even position. The PSC expenditures grow or contract based upon fluctuations in demand for services. Services are provided in four broad business areas: human resources, including civil service and commissioned corps; financial management; administrative operations; and, occupational health. The Office of

the Deputy Assistant Secretary for Program Support also provides services to the health agencies under the provisions of the Freedom of Information Act (FOIA). Services include the processing of all FOIA requests involving more than one health agency; processing all health agency administrative appeals for the signature of the Deputy Assistant Secretary for Public Affairs; and providing department-wide training and consultation on FOIA matters. The Office of the Chief Information Officer also resides in the Office of the Director and is the focal point within PSC for managing the activities required to maintain an agency-wide information technology program.

Descriptions of the major Service areas follow:

HUMAN RESOURCES SERVICE

The Human Resources Service (HRS) provides personnel and payroll services to the HHS and provides leadership in personnel administration to the PSC. The mission of HRS is to provide high quality human resource services at competitive prices to a multi-customer base of HHS components. The overall goal of HRS is to be widely recognized as the leader in providing quality, cost competitive personnel operations services and personnel and payroll systems support to the Department.

HRS provides customized and complete human resource service packages including automated personnel and payroll systems support, personnel and payroll processing, recruitment, staffing and classification, and employee and labor relations. These services are available to all components of HHS.

The staff provides policy implementation, oversight, and technical assistance to the PSC and to components of the Office of the Secretary, the Administration for Children and Families, the Administration on Aging, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration, in the areas of Equal Employment Opportunity, career management, recruitment, employee relations, labor-management relations, employee development, employee assistance programs, recruitment, classification, and compensation.

HRS manages the Department's payroll operations, providing pay services to all HHS employees every pay period, serving over 63,000 employees each month. This activity keeps current and historical personnel, pay and leave records on HHS civilian employees.

COMMISSIONED PERSONNEL SERVICE

The PSC also provides services to the U.S. Public Health Service Commissioned Corps through its Division of Commissioned Personnel (DCP). DCP integrates the development, implementation, and evaluation of a comprehensive program for personnel management, medical support systems, and pay administration for the Commissioned Corps. DCP develops and monitors interagency agreements and reimbursements for direct health services, payroll services and detail of officers to Federal agencies. DCP provides a full range of personnel services and activities to HHS and non-HHS agencies

and programs that employ PHS Commissioned Corps officers, and to the active-duty, inactive, and retired officers' populations. DCP advises the Office of the Surgeon General on matters of PHS Commissioned Corps policy and administration, provides authoritative legal counsel, and advises on legislative and regulatory proposals, procedural, and policy issuances. DCP prepares advisory opinions to the Board for Correction of PHS Commissioned Corps Records, and serves as principal PHS representative in Boards of Inquiry.

FINANCIAL MANAGEMENT SERVICE

The Financial Management Service supports the financial operations of HHS and other Departments through the provision of payment management services for departmental and other Federal grant and program activities, accounting and fiscal services, debt management services, travel management, and resource management services; and the review, negotiation and approval of rates, including indirect cost rates, research patient care rates, and fringe benefit rates.

ADMINISTRATIVE OPERATIONS SERVICE

The Administrative Operations Service provides a wide range of services to customers in the Department, as well as to customers throughout the Federal Government. The major service areas are: acquisition management; real property management, which includes facilities management, leasing, and disposition of surplus Federal property; personal property management, including warehousing and inventory control; communications management, which includes telecommunications, visual communications, reprographics, automated library and reference management, and mail and messenger services; and, health supply management, which includes the provision of pharmaceutical, medical, and dental supplies.

FEDERAL OCCUPATIONAL HEALTH SERVICE

The Public Health Service Act authorizes the heads of Federal agencies to provide occupational health services to their employees. The Federal Occupational Health Service (FOH) currently provides occupational health services, including health, wellness, employee assistance, work/life, safety, environmental assessments and industrial hygiene-related services to more than 160 Federal components across the country. These services are provided through more than 3,200 Interagency Agreements as authorized under the Government Management Reform Act and the Economy Act.

FOH provides direct occupational health services through three product line organizations. Currently FOH provides a variety of clinical services to 326 different government entities; the employee assistance product line to 174 different entities and the environmental health product line to 88 different government entities.

INFORMATION TECHNOLOGY

The PSC's FY 2004 President's Budget includes funding to support Departmental efforts to improve the HHS Information Technology Enterprise Infrastructure. The request includes funds to support an enterprise approach to investing in key information technology infrastructure such as security and network modernization. These investments will enable HHS programs to carry out their missions more securely and at a lower cost. Agency funds will be combined with resources in the Information Technology Security and Innovation Fund to promote collaboration in planning and project management and to achieve common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software.

Our budget request includes savings in the Information Technology (IT) budget from ongoing IT consolidation efforts, and additional reduced spending through the streamlining or elimination of lower priority projects.

We are participating in the consolidation of Information Technology infrastructure support staff service across the eight smaller HHS Operating Divisions.

FY 2002 ACCOMPLISHMENTS

PSC's significant FY 2002 accomplishments include:

- Achieved unqualified 'clean' audit opinions for all six customer OPDIVs (Administration for Children and Families, Administration on Aging, Indian Health Service, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, and the Agency for HealthCare Research and Quality), a first in PSC history. Most noteworthy was the first clean opinion for the Indian Health Service, a significant accomplishment given the scope and nature of their financial situation. Additionally, there were no new material weaknesses in all six of those audits.
- The Payment Management System team processed more than 300,000 payments totaling more than \$244B to grantees while collecting approximately \$10M in interest earned on Federal Funds on deposits with grantees.
- Brought the HHS Department on-line to the new state-of-the-art PeopleSoft personnel system.
- Successfully implemented a number of best practices and state-of-the-art automated tools to enhance the HR process and improve customer relations.

- Implemented a security awareness program that included providing security training to more than 1,300 PSC employees and contractors.
- A comprehensive PSC Competitive Sourcing Plan was developed, and approved. The FY 2002 competitive sourcing goal of 5% was exceeded. Of the total 75 FTEs studied in FY 2002, 60 regional administrative support FTEs were converted to contract under a competitive selection process. The remaining 15 FTEs, which were comprised of seven different activities, were directly converted under existing contracts.
- Regional Offices were converted to contractor and Inter / Intra-service Support Agreement (ISSA) support, resulting in a first year savings of almost \$1M and anticipated savings of approximately \$3M in subsequent years. Impacted employees were placed in other positions within HHS.
- Began and substantially completed development of a new PSC billing system in FY 2002. The PSC Revenue, Invoicing, and Cost Estimation System (PRICES) was delivered and made operational on November 15, 2002.
- In FY 2002, the PSC completed 17 Business Case Analyses (BCA) of our business lines. These include EHRP, Work Life Center, Carpet, Copy Paper, Forms and Publications, Motor Pool, Office Movers, Rehab Furniture, Shipping and Handling, Shredding, General Storage, Asset Management, Property Disposal, One-Stop Shop (Relocations), Conference Center, Graphic Arts, Reprographics, and one BCA for the National Institutes of Health (NIH Motor Pool). The remainder of the PSC's business lines will be studied in FY 2003. Firm estimates of the savings associated with these recommendations are not yet available as implementation of the resulting recommendations is on-going, but initial figures indicate that savings for these BCAs alone could be in the \$3M to \$4M range. These savings are in addition to substantial improvements in processes, quality, and customer service.
- Prepared transition plans and began implementation of several best business practices affecting our product lines.
- Increased efforts toward solving customers' health professional manpower shortages -- doubled the number of professionals who applied for appointments in the commissioned corps through aggressive recruiting efforts, such as recruiting trips, advertising, and involving university faculty, which resulted in a 50% increase in new calls to duty in 2002. Total new calls to duty in FY 2002 were 550 officers; the overall recruitment goal is to reach 7,000 by the end of FY 2005.
- The Commissioned Officer Training Academy presented the new Basic Officer Training Course to over 1,200 newly commissioned officers. This course helps officers and managers better understand the personnel system, avoids errors and

disciplinary actions, and should result in better retention over time, thereby reducing some of the losses which cause health professional talent shortages.

- FOHS grew its business by 17% in the year, primarily due to huge demands for services from its customers engaged in National and Homeland Defense.
- A Web-based time and attendance system has been deployed to all interested Department agencies. The following agencies are currently using this system: National Institutes of Health, Office of the Secretary, Administration on Aging, Administration for Children and Families, Agency for HealthCare Research and Quality, Indian Health Service, Substance Abuse and Mental Health Services Administration, and the PSC. The Centers for Medicare & Medicaid Services is now interested and will be deployed in FY 2003.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

HUMAN RESOURCES SERVICE

Authorizing Legislation - 42 USC 231

	FY 2002	FY 2003	FY 2004	Increase/
	<u>Actual</u>	<u>Estimate</u>	<u>Estimate</u>	<u>Decrease</u>
Amount	\$41,017,000	\$51,617,000	\$51,605,000	-\$12,000
FTE	264	264	264	0

FY 2004 Authorization Indefinite

Purpose and Method of Operation

The Human Resources Service (HRS) provides personnel and payroll services to the Department of Health and Human Services (HHS) and leadership in personnel administration to the PSC. The mission of HRS is to provide high quality human resource services at competitive prices to a multi-customer base of HHS components. The overall goal of HRS is to be widely recognized as the leader in providing quality, cost competitive personnel operations services and personnel and payroll systems support to the Department.

HRS provides customized and complete human resource service packages for civilian personnel including automated personnel and payroll systems support, personnel and payroll processing, recruitment, staffing and classification, and employee and labor relations. These services are available to all components of HHS.

The staff provides policy implementation, oversight, and technical assistance to the PSC and to components of the Office of the Secretary, the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, and the Administration on Aging. HRS services include Equal Employment Opportunity (EEO), work and family, career management, recruitment, employee relations, labor-management relations, employee development, recruitment, classification, and compensation.

HRS manages the Department's payroll operations, providing pay services to all HHS civilian employees every pay period, issuing over 72,000 W-2s each year. This activity keeps current and historical personnel, pay and leave records on HHS civilian employees.

Personnel operations services are provided to 7,500 departmental staff headquartered in southwest Washington, D.C., Silver Spring and Rockville, Maryland by local personnel servicing offices. HRS provides a Board for Correction of PHS Commissioned Corps Records to which an officer appeals for the correction of official personnel records.

The EEO Complaints Investigation office provides investigative services contractual oversight to departmental OPDIVs at a rate of approximately 200 investigations each year.

The HHS University provides department-wide training and workforce development services. It establishes and manages a corporate university which develops, presents, and manages common needs training across the Department.

FY 2004 OBJECTIVES

HRS has set the following strategic directions that are geared to improve service and promote greater efficiency.

- Performing the transition to a consolidated, non-HHS payroll system and provider.
- Developing a comprehensive servicing strategy that targets products and services that will realize the greatest return on investment for our customers.
- Achieving further gains in customer service satisfaction through quicker response time, improved quality follow-up, and resolution of issues.
- Fully support the One Department initiative by participating in the implementation of the HR consolidation effort within HHS.
- Implementing procedures to increase accuracy and quality of personnel actions.
- Completing the establishment and institution of the HHS University.
- Providing workforce planning services to HRS customers.
- Reducing costs in labor relations services by the use of alternative discipline and dispute resolution processes thus resolving a greater rate of grievance resolution prior to reaching formal stage processes.
- Continuing to refine services and to automate HR processes wherever possible.

Rationale for the Budget Request

FY 2004 expenses for the Human Resources Service are estimated at \$51,605,000, a net decrease of \$12,000 from the FY 2003 level. This reflects built-in increases for pay raises and other items which are offset by savings in administrative and overhead costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

COMMISSIONED PERSONNEL SERVICE

Authorizing Legislation - 42 USC 231

	FY 2002 <u>Actual</u>	FY 2003 <u>Estimate</u>	FY 2004 <u>Estimate</u>	Increase Or <u>Decrease</u>
Amount	\$17,161,000	\$19,477,000	\$18,951,000	-\$526,000
FTEs	103	103	103	0

FY 2004 Authorization..... Indefinite

Purpose and Method of Operation:

The PSC provides service to the U.S. Public Health Service Commissioned Corps through its Division of Commissioned Personnel (DCP). The DCP integrates the development, implementation, and evaluation of a comprehensive program for personnel management, medical support systems, and pay administration for the Commissioned Corps; develops and monitors interagency agreements and reimbursements for direct health care services, payroll services, and detail of officers to other Federal agencies; and also provides a full range of personnel services and activities to the Department of Health and Human Services (HHS) and non-HHS agencies and programs that employ PHS Commissioned Corps officers and to the active-duty, inactive, and retired officers' populations.

The DCP Office of the Director advises the Office of the Surgeon General on matters of commissioned corps policy and administration, and advises on legislative and regulatory proposals, procedural and policy issuances. DCP implements regulations and policies pertaining to promotions, awards, career development, equal opportunity, disciplinary action, performance evaluation, reassignment, retirement, and leave for commissioned officers.

DCP prepares advisory opinions to the Board for Correction of PHS Commissioned Corps Records and serves as the principal representative in Boards of Inquiry. A Board of Inquiry is a hearing convened by the Secretary or his/her designee, for the purpose of receiving evidence and making findings and recommendations regarding an officer's performance and/or conduct in determining whether and under what conditions an officer should be retained on active duty or separated from active duty, and if separated from active duty, the characterization of the separation/discharge. DCP also coordinates the internal control review process for the Service, and advises the Surgeon General's policy Advisory Council Representatives, Commissioned Corps Liaisons, Chief Professional Officers and Chairpersons of the Professional Advisory Committees.

Compensation and Retirement. DCP provides a comprehensive program of compensation and retirement services for the Commissioned Corps. DCP administers a system of active-duty pay that includes basic pay, special pay, allowances, a system of pay for retirees, annuitants, and former spouses. It identifies and collects debts to the Federal Government and interfaces with the Department of Defense (DOD) in coordinating pay benefits in concert with HHS' policies and procedures. It analyzes the pay system including the administration of an actuarial analysis contract on officers' retirement pay, survivor assistance, and benefits programs. DCP coordinates with the Department of Veterans Affairs (VA) for the Service Member's Group Life Insurance Program and VA benefit offsets, and provides for all voluntary and involuntary payroll deductions.

Medical. DCP manages and directs health services for PHS commissioned officers. It develops operational policies and procedures and clinical benefit packages for PHS designated beneficiaries' direct health care programs. It is responsible for the overall management and direction of the PHS Commissioned Corps health care entitlement programs for designated beneficiaries in accordance with applicable laws and policies.

DCP authorizes health care services to eligible beneficiaries from private providers and certifies billings for payment. It carries out the Department's responsibilities for the Civilian Health and Medical Program of the Uniformed Services (TRICARE) Program and maintains liaison with the DOD's direct healthcare system for eligible PHS beneficiaries. DCP develops and monitors the Medical Division's automated management information systems, monitors officers on medical limited tours, and makes determinations of physical qualifications for removal of medical limited tour status, extension of medical limited tour or separation for failure to meet physical qualifications.

DCP determines the fitness of officers to continue on active duty to assure that they are physically capable of carrying out the missions of their programs. DCP provides credentialing for Federal health care providers and assures that benefits such as sick leave, temporary duty limitation, and disability retirement are properly provided to officers. It provides medical policy advice to commissioned officers, their families and legal representatives, management officials of the Federal Government, civilian military physicians, Congressional and Senatorial staff members, and the Surgeon General.

Officer Support. DCP provides a full range of administrative support, consultation, and policy development to the commissioned corps regarding personnel matters. It administers promotion and assimilation systems, and coordinates all board activities related to promotion, assimilation, Flag and Chief, Professional Officer selection and appointment systems.

DCP conducts a basic officer training program for newly commissioned officers and develops ongoing training for officers and civilian personnel. It administers the awards and billet programs for officers and manages the officers' performance evaluations and rating systems. DCP coordinates the PHS uniform policies and procedures, the officers' and dependents' enrollment in the Defense Enrollment Eligibility Reporting System. It coordinates the enrollment in the Veterans Educational Assistance Program and administers the probationary tour of duty program for officers, and monitors their professional licensure, certification, and registration status. DCP coordinates the PHS long-term training programs, monitors training obligations, coordinates and maintains debt collections, and maintains official personnel records for all officers. DCP coordinates the Privacy Act and Freedom of Information Act access to official records and issues official personnel orders for all active-duty officers.

Recruitment. DCP serves as the primary agent of the Department for the recruitment of qualified new officers to the PHS Commissioned Corps. DCP markets the Commissioned Corps through the use of public relations tools such as Web sites, videos, CD-ROM, brochures, and public appearances. It focuses on attracting talented professionals with specific skills.

DCP manages and coordinates the activities related to the application process which includes the collection of applicable data pertaining to the applicant's file, security and background clearances, selection of qualifying appointment boards, and student opportunity programs (Junior and Senior Commissioned Officer Student Training and Extern Programs). It processes medical clearances, calculates dates pertaining to the officer's pay and rank, communicates the various commissioned corps policies and procedures to the hiring agencies, and issues the call-to-duty and related personnel orders.

DCP processes all special assignments and details to States, international organizations, other Federal agencies, and Congressional committees through the execution of Memorandums of Understanding and reimbursable agreements.

FY 2004 Objectives

DCP has set the following strategic directions and objectives that are geared to improve service for its customers and promote greater efficiency in its overall operations.

- Identify and implement a suitable replacement for the Commissioned Corps personnel and payroll system which is over 20 years old. The objective of this change is to enhance service to the customer while reducing the overall cost of processing.
- Improve quality of services through access to health care and claims processing. This includes: (1) out source 70% of health care claim processing responsibility to TRICARE to improve claim processing, and (2) explore and develop a process for providing beneficiaries with a more convenient method of tracking medical claims processing and payments.
- Complete a Business Case Analysis on business lines and practices.
- Develop web-based tool to enable hiring officers to review assignment preferences and special skills of Commissioned Corps applicants.
- Develop web-based tool to enable hiring officials provide feedback to DCP on jobs offered to and accepted by applicants.
- Make the Basic Officers Training Course available to all new commissioned officers in all of HHS and other Federal agencies. Develop and implement an independent training system through remote access to web technology to allow officers the opportunity to educate themselves on advanced subject matters.

Rationale for the Budget Request

The FY 2004 expenses for this activity are estimated to be \$18,951,000, a net decrease of \$526,000 from FY 2003 estimated level. This change is the net result of increased operating costs for built-in pay raise and other increases offset by savings in administrative and overhead costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

FINANCIAL MANAGEMENT SERVICE

Authorizing Legislation - 42 USC 231

	FY 2002 <u>Actual</u>	FY 2003 <u>Estimate</u>	FY 2004 <u>Estimate</u>	Increase or Decrease
Amount	\$53,510,000	\$56,702,000	\$55,787,000	-\$915,000
FTE	243	258	258	0

FY 2004 Authorization.....Indefinite

Purpose and Method of Operation

The Financial Management Service (FMS) supports the financial operations of the Department of Health and Human Services (HHS) and other Departments through the provision of payment management services for Departmental and other Federal grant and program activities; accounting and fiscal services; debt management services; travel management, resource management services; and the review, negotiation and approval of rates, including indirect cost rates, research patient care rates, and fringe benefit rates. Discussions of these major components of the Financial Management Service follow.

Division of Payment Management

The Division of Payment Management (DPM) provides a centralized electronic funding and cash management service to all organizations receiving HHS grants and contracts, and to organizations funded by 10 other Federal agencies. In addition to making automated payments, DPM monitors funds held by grant recipients and manages the collection of over-advanced amounts based on grantee overestimates of cash requirements. The DPM achieves economies of scale through the cross servicing of many agencies.

The DPM also functions, as directed by the Office of Management and Budget, as the Federal Government's central collection point for all interest earned on undisbursed grant funds, regardless of the funding organization.

The DPM operates and maintains the Payment Management System (PMS). This system is capable of receiving automated or manual payment requests, editing them for accuracy and content, batching them for forwarding to the Federal Reserve Bank for payment, and recognizing and posting them to the appropriate general ledger accounts.

On-line inquiry capabilities allow all PMS users and clients to determine the status of their respective accounts on a real-time basis. Payment timing and amounts can be checked, balances verified, collection information confirmed, and funding levels and grant award amounts verified. Access is by dial-up modems or through our web page on the Internet.

Significant increases in the level of service to both granting agencies and grant recipients have been achieved with a single point of contact for almost all financial matters. Ninety-five percent of all grant recipients now request their funds electronically, and over ninety-eight percent of all funds are delivered electronically. The DPM is participating in Treasury's Remittance Express System which allows the Government to receive electronic fund transfers through the Federal Reserve Bank.

At the end of FY 2002, DPM was servicing 23,620 recipient accounts, an increase of approximately 15 percent from FY2001. Demographically, 11,219 were colleges, universities, and non-profits; 2,127 were State and local governments; 1,502 were tribal organizations, and 8,773 were for non-HHS agencies. Total FY 2002 payments amounted to \$244 billion, and of the 313,640 payment transactions, virtually all were by electronic fund transfers.

Division of Financial Operations

The Division of Financial Operations (DFO) provides full accounting and fiscal services for the PSC and several other HHS agencies (Office of the Secretary, Administration for Children and Families, Administration on Aging, Indian Health Service, Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, and the Agency for Healthcare Research and Quality).

The DFO accounting and financial management systems all comply with Generally Accepted Accounting Principles as outlined by the Federal Accounting Standards Advisory Board. In addition, DFO adheres to Federal fiscal laws and regulations mandated by the General Accounting Office (GAO), Office of Management and Budget, General Services Administration, and the Department of the Treasury. These Federal agencies require periodic fiscal reporting in various forms, including financial statements which are subject to independent audits.

The major statutes that govern DFO operations are: the Chief Financial Officers Act of 1990, the Certifying Officers Act of 1941, the Prompt Payment Act of 1989, the Federal Managers' Financial Integrity Act of 1982, the Government Management Reform Act of 1994, the Government Performance and Results Act of 1993, the Debt Collection Improvement Act of 1996, and the Federal Financial Management Improvement Act of 1996.

The proprietary and budgetary accounting principles are applied to appropriations, allotments and allowances in processing cash receipts, recording purchases (obligations), accruals, disbursements, payroll, and inventory control. All obligations recorded in the accounting system by DFO follow the GAO guidelines of the Principles of Federal Appropriations Law.

The DFO is designated the Debt Collection Center for HHS and employs innovative techniques of collection. The services provided include day-to-day interaction with the Department of Justice and the Department of the Treasury in successfully collecting overdue accounts. Collections are deposited within 24 hours.

The DFO records all obligations into the accounting system based on procurement documents issued by authorized contracting officers and purchasing agents. These obligation transactions which update the budgetary accounts and weekly reports are produced for monitoring by agency budget officers.

The DFO provides disbursement services for the payment of vendor invoices based on obligated fund authority. Special unique disbursing services include payments for student loan repayments, scholarship payments, subsidy payments, vaccine injury compensation payments, beneficiary medical payments, and payments to contractors operating Federal clinics. Full interagency accounting services are provided via electronic communications through the Treasury Intra-governmental On-line Payment and Collection System (IPAC).

The DFO furnishes fiscal advice and provides technical and policy guidance to headquarters program offices and field accounting activities. The DFO ensures that expenditures are made in accordance with appropriations law. Additionally, the DFO prepares auditable financial statements and reports for internal and external use.

The Unified Financial Management System (UFMS) will be implemented to replace five legacy accounting systems currently used across the Operating Divisions. The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. It will also promote the consolidation of accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable agencies and program administrators to make more timely and informed decisions regarding their operations. As part of this Departmental effort, the PSC has expanded its role in the development of UFMS by coordinating with the Department's contractor and developing a consolidated list of core financial system requirements for the PSC and its customer operating agencies to link with Department-wide system requirements for all of its financial management system business.

Division of Cost Allocation

Another major component of the Financial Management Service is the Division of Cost Allocation (DCA). The DCA carries out the following responsibilities:

- Reviews, negotiates and approves indirect cost rates, State and local government cost allocation plans, research plans, research patient care rates and/or amounts, fringe benefit rates, and other special rates for organizations receiving federally sponsored awards;

- Serves as liaison with Federal agencies on operational matters involving review and negotiation of indirect cost rates and cost allocation plans;

Resolves audit findings on cost allocation plans, indirect cost rates, etc.;

Provides technical assistance on indirect cost and cost allocation matters to Federal agencies and organizations receiving federally sponsored awards;

Performs functions described above on behalf of all Federal agencies when HHS is designated the cognizant agency by OMB;

Negotiates indirect cost rates on behalf of other Federal cognizant agencies on a reimbursable basis;

Collects rate agreements (issued by HHS and other Departments) for organizations not subject to the commercial cost principles and distributes them on a government-wide basis;

Evaluates a wide range of ADP and telecommunication facilities operated by State/local governments, colleges and universities, and other nonprofit organizations to determine whether charge backs for services to Federal programs are reasonable, proper and allowable under Federal cost principles; and

Maintains the Cost Allocation Management Information System; the Indirect Cost Rate Information System; the Rate Agreement Distribution System; and the Statistical Analysis System in support of DCA activities.

Division of Information Systems and Technology

The Division of Information Systems and Technology (DIST) is responsible for providing ADP systems development and support to the HHS agencies. This includes providing monthly workforce highlights, FTE and staffing reports, and other official resources management information. This division develops and maintains large applications systems such as the Workforce On-line Data System, the Training Management Information System and the Performance Management System. The DIST provides guidance and technical expertise to the HHS agencies in the areas of workforce analysis, microcomputer technology, and human resources information systems.

Some of the services DIST provides include:

- Basic Services - Monthly production of FTE reports, regular reports, Workforce Highlights, Ad Hoc queries.
- HHS Careers - Set up users, maintain system, provide reports, and post to OPM and Internet sites.
- Workforce On-line Data System - Register users, maintain and update systems, upgrade capabilities, unlimited training and assistance.
- Performance Management System - Provide software, data files, and assistance.

- Training Management Information System - Provide data file, maintain system, manage reporting system and provide assistance.

FY 2004 Objectives

The Financial Management Service (FMS) has established the following objectives for FY 2004:

- Continue to improve security for FMS systems.
- Resolve all reportable conditions, under control of the PSC, identified in the audit of financial statements.
- Continue unqualified opinion on PSC and customer agency financial statements.
- Work with the Deputy Assistant Secretary for Finance to improve the grant accrual process.
- Successfully meet quarterly financial statement requirements for the PSC and customer agencies.
- Complete Business Case Analyses on business lines and practices.
- Complete 85 percent of all indirect cost rate proposals within 6 months of receipt.
- Review and process 85 percent of statewide cost allocation plans within 12 months.
- Complete 95 percent of assigned audit resolution activity within 6 months of receipt.
- Increase non-waivered electronic disbursements.
- Maintain our prompt payment and electronic disbursement percentages.
- Increase electronic reporting of 272 Reports (PMS) by 10 percent.
- Increase yield of debt management services and refer verified delinquent debts to the Treasury Offset Program.
- Continue to maintain erroneous payment goals.

- Continue to review and implement refined billing methodologies.
- Increase the non-HHS customer base serviced by the Payment Management System.
- Increase customer satisfaction with FMS services.

Rationale for the Budget Request

The FY 2004 expenses for Financial Management Service are estimated at \$55,787,000, a net decrease of \$915,000 from FY 2003. This change is the net result of increase operating costs for built-in pay raise and other cost-increases which have been offset with savings in administrative and overhead costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

ADMINISTRATIVE OPERATIONS SERVICE

Authorizing Legislation - 42 USC 231

	<u>FY 2002 Actual</u>	<u>FY 2003 Estimate</u>	<u>FY 2004 Estimate</u>	<u>Increase or Decrease</u>
Amount	\$182,339,000	\$191,791,000	\$193,855,000	+\$ 2,064,000
FTE	428	402	402	0

FY 2004 Authorization Indefinite

Purpose and Method of Operation

The Administrative Operations Service (AOS) provides a wide range of services to customers in the Department and to customers throughout the Federal government. The major service areas are: acquisition management, real property management, which includes facilities management, leasing and disposition of surplus Federal property; personal property management including warehousing and inventory control; communications management which includes telecommunications, visual communications, reprographics, automated library and reference management, and mail and messenger services; and health supply management, which includes the provision of pharmaceutical, medical, and dental supplies.

Acquisition Management

The Division of Acquisition Management solicits, negotiates, awards, and administers simplified acquisitions and complex contracts in such areas as information technology, programmatic research and development, health care and support services, professional services, construction and renovations, labor services, computer/office machine repairs, real property leasing and commercial products. These services are provided to HHS components both at headquarters and in the regions, as well as to customers outside the Department. Highly trained, experienced, and specialized staff provide a wide array of acquisition, claims, grant, cost advisory, and small business advocacy services utilizing state-of-the-art technology, including electronic commerce and internet ordering.

The Division's automated procurement application, PRISM, and our use of web technology, continue to improve competition, cost savings, and timeliness for our customers. Customers benefitted from over \$4 million in cost avoidance obtained through PSC competition and negotiation of simplified acquisitions and contract obligations. In FY 2002, total simplified and contract obligations reached \$472 million.

The Division, through its creation of innovative, cost effective, and user friendly acquisition vehicles, has continued its relationship with customers such as the Departments of Education, Defense, Justice and Labor, as well as the National Science Foundation, Federal Aviation Administration, National Institute of Standards and Technology, Office of National Drug Control Policy, U.S. Marshals Service and the Federal Emergency Management Agency. Through interagency agreements, in FY 2002 the Division was able to award over \$13 million in task orders and other contract mechanisms on behalf of these external customers.

The Division continues to support the District of Columbia. Awards totaling close to \$10.5 million were made on behalf of the District of Columbia for FY 2002. The Department of Mental Health and the Department of Health each benefitted from a reduced PSC fee for service as a result of a modification made to the original agreement rewarding the volume of obligations.

The Division is responsible for administering the Government-wide purchase card program for OS, OPHS, AOA, ACF, and the PSC both at headquarters and on behalf of the regional offices. The program remains strong showing an increase in card holders, the number of transactions, and total sales for FY 2002 (close to \$33 million). Customers are encouraged to use purchase cards for eligible acquisitions; currently purchase cards are used for 98.7% of eligible acquisitions.

The HHS procurement offices have adopted a measurement system for assessing performance and improving the delivery of services. The system uses a common and balanced set of procurement performance measures developed by HHS and other Federal agencies and endorsed by the Office of Management and Budget and the President's Management Council. The system helps achieve program missions; reinforces HHS's strategic direction and core values; gives executives a useful decision-making and communications tool for day-to-day contract, program, and risk management; promotes sharing of best practices; fosters continuous improvement in acquisition management; and assesses our progress in implementing procurement reform initiatives. In FY 2000 the PSC surveyed its acquisition employees, customers, and vendors. The results were good and plans are being made to conduct a new customer survey in FY 2003.

The Division continues to provide claims processing support to agencies of the Public Health Service. The Claims Branch processed over 448 Federal claims totaling over \$10 billion in FY 2002. The number of claims filed continues to increase as the claims function now covers over 700 community clinics throughout the country with 14,000 health care professionals.

The Bush Administration has established a goal of using Performance-Based Contracting to award 20 percent of eligible service contracting dollars by FY 2002. The PSC has maintained an aggressive approach as one of the Department's leading advocates for performance-based contracting. Through our efforts, the PSC awarded 50 percent of PSC's eligible service contract dollars as performance-based in FY 2002.

Property Management

The PSC has responsibility for three delegated buildings, which are Parklawn at Fishers Lane in Rockville, Md, the Park Building also in Rockville, and the Personal Property Facility in Gaithersburg, Md. There is approximately 110,000 square feet in Gaithersburg, 1.3 million square feet in Parklawn, and 90,000 square feet in the Park Building. Workload includes property management, utilities, mechanical management of government-owned equipment, security, and custodial.

Over the past years, the AOS has developed and continually improved its state-of-the-art Computer Aided Design/Computer Aided Facility Management system. This system provides an automated process from the initial design of renovations and alterations on through the final production of the contract for services and supplies. This system also maintains an accurate library of all space assignments. Rent charges are based on these figures. AOS maintains an aggressive energy management program utilizing such resources as Energy Performance Savings Contracts, rebates, and utility savings to implement conservation projects in the Parklawn Building. This has enabled AOS to meet or exceed national mandated energy goals and to earn "Showcase Facility" recognition from the Federal Energy Management Program, Department of Energy.

AOS operates a state-of-the-art Personal Property Facility (PPF) equipped with a radio frequency driven warehouse management system that maximizes space utilization allowing for new business ventures. The PPF is staffed with experienced personnel to provide for the storage, inventory management, material and product distribution, reutilization, disposal or shipment of Government owned personal property. An on-line ordering system utilizing website technology allows customers around-the-clock access to personal property products and services. The website features flexible payment methods with e-mail order confirmation. Participating customers in need of equipment and furniture are offered several program designed to save valuable resources. Services are offered on a fee-for-service basis to all agencies throughout the Federal Government.

As a result of several business cases, the Personal Property Facility has made some major transitions during FY 2002 as follows:

- After many years of refurbishing Class "A" furniture, PSC entered into an agreement with USDA to provide them salvageable furniture and agreed to fill Class "A" furniture demand through them. In the meantime, we are working with customers to assist them in transitioning to systems furniture, which is much more functional.
- PSC has been storing carpet for moves and relocations. We have now contracted with a local vendor with "Just in Time Delivery"/ The carpet is ordered as needed and delivered to the job. This resulted in a better grade of carpet at a lower price.

- Both of these initiatives freed up approximately 9,000 square feet in our Personal Property Facility. We then worked with our Supply Service Center in Perry Point, Md. To partner with the U.S. Army in providing support for packing and shipment of medical supplies. We have already shipped over 564 pallets of medical supplies.
- We also performed our own shredding services; however, we have now turned in our equipment and contracted this service out, reducing our cost at least 50% for the customer.

AOS administers the Department's Federal Real Property Assistance Program. Surplus Federal real property is transferred to state and local government agencies and nonprofit organizations for public health and homeless assistance purposes.

There is a thirty-year restrictive period in which transferred property must be utilized for the approved public health or homeless program. Use of the property is monitored through annual utilization reports provided by the public health or homeless provider and through periodic site visits by members of the Real Property Branch.

Technical Support

The Division of Technical Support (DTS) provides expertise in telecommunications, visual communications, printing procurement and publications management, reprographics, automated library and reference management, conference room facilities, and mail and messenger services. DTS is committed to providing high quality, timely and responsive technical support services on a cost effective, customer friendly, competitive, fee-for-service basis to customers throughout the Federal and D.C. Governments.

Telecommunications staff receive and administer service requests for all HHS agencies in Washington D.C., Maryland, and in 10 regions throughout the country under the WITS 2001 and the FTS 2001 contracts. The WITS 2001 contract is a multi-year contract which expires in January 2008. The variety of services provided includes: ISDN, voice mail, video conferencing, local area network (LAN) connections, FTS2001 services, 800 service, Fiber Network Service, domestic and international long distance calling, voice, facsimile and data lines.

The Printing and Postal Technologies Branch (PPTB) continues to meet the needs and requirements of its customers. This is done through acquiring and implementing technological advances that continue to be beneficial in both cost and level of service to our customers. The PPTB's utilization of the Pitney Bowes AccuTrac HT Postal Accounting System provides up to the minute cost data to our customers as it pertains to workload and postal expenditures. The electronic connection of all meters nationwide produces accurate, immediate, electronic postal and shipping cost reports which serve as a vital workload analysis tool and as the primary reporting method for cost expenditures to the customer. This system has greatly enhanced the PPTB's ability to verify (for

payment) over \$6,000,000 yearly in postal costs on behalf of HHS agencies. The Pitney Bowes AccuTrac system also provides our customers the accountability and detailed information required to manage a large-scale mail operation. The PPTB maintains two digital copiers that incorporate scan-to-file technology. Over 8,000 printing procurement records have been scanned creating a permanent electronic database that is accessible by all employees of the PPTB as well as outside partners.

The PPTB continues to maintain a blanket simplified purchasing agreement with the Government Printing Office providing improved printing procurement services to our customers. This agreement allows for the solicitation of bids and the award of orders directly from the PPTB office. This is one more step in which the PSC is improving the service, quality, and reducing costs for the quality printed products procured on behalf of our customers.

The Media Arts and Reprographics Branches are in the process of converting from analog to digital technology in offered services, which include videoconferencing, photography, Internet available forms, and high-speed digital reproduction.

Within the Media Arts Branch (MAB) are four lines of business - Graphics, Photography, Conference Control and Audio/Visual. MAB provides these services to all HHS Agencies, the Office of the Secretary as well as other Departments. MAB Graphics Services provided over 6,000 separate job requests last fiscal year. Many projects are highly technical and involve several production stages prior to completion. Most assignments have tight deadlines, and virtually all deadlines in the past 5 years have been met. Much of the design and production of MAB is directed towards satisfying the graphic needs of our various HHS clients.

Utilizing the latest computer driven color printers, the Graphics Section produces full color posters, banners, large presentation charts, or full color display graphics in-house with a relatively short turn around time. Images 3 feet by up to 10 feet (or more) are possible and are produced daily for HHS customers. In addition to a highly trained professional staff, the Media Arts Branch has 8 in-house contractors as well as more than 30 specialized service contracts on call to support its operations and ensure all deadlines are met. Graphics also provides design and layout for both publications and forms. MAB is now a primary resource for the conversion of all HHS forms to meet the handicapped accessible Section 508 requirements for electronic forms, which are universally accessible on the Internet.

MAB also has a state-of-the-art Photo Section, which produces thousands of photos and 35mm slides per year and provides high quality photographic services to customers. Portrait photography for Agency Senior Staff and awards photography are executed in a new state-of-the-art photo studio located within the Branch. The staff photographer also spends much time "on location" at sites around the Metro Washington area in order to capture and produce high quality photos for our customers' publications or to document research. MAB provides architectural photography (both interior and exterior) including

aerial photos when needed. In addition, MAB provides passport photos, journalistic photography, and 35mm slide photographs for presentations and multimedia use.

The Conference Control and Audio/Visual group provide three primary services - conference room reservations, computer lab reservations, and audio/visual equipment rentals used to support events for all Federal agencies. Conference rooms can be used for official departmental business, as well as some unofficial business. For example, groups that advocate health issue awareness may use the facility. The Conference Center offers a professional staff of audiovisual technicians who provide services that include the latest technology for wide-band videoconferencing, satellite downlink broadcasts and distance learning. In addition, LCD projection systems are available for use with computer-generated, large screen presentations.

The Parklawn Health Library continues to provide desktop access to its web-based online catalog, monthly Bulletin, database searches, topical bibliographies, health news, and links to other health related Internet sites. In addition, users can request literature searches, interlibrary loans, and obtain online reference assistance. The library is now offering its primary clients electronic full text access to select journal titles.

Supply Management

AOS operates a full service medical supply depot located in Perry Point, Maryland. The Supply Service Center (SSC) provides pharmaceuticals, medical and dental supplies to more than 4,500 Federal health care facilities worldwide. An inventory of more than 6,000 line items is maintained to meet the needs of its customers and provide an economical source of supply for all Federal customers.

SSC is licensed by the Food and Drug Administration as a Drug Repackager. Tablets and capsules are repackaged into economical unit-of-use containers that are customized to the Federal customers' requirements and needs. Strict quality control standards are maintained by the Center to assure compliance with all Current Good Manufacturing Practice Regulations of the FDA. SSC also manages, repackages and distributes study drugs for National Institutes of Health's sponsored clinical drug trials.

SSC also produces and distributes customized medical, dental and diagnostic kits for the Office of Emergency Preparedness, State Department, Peace Corps, Department of Defense Agencies, i.e., Army, Navy, Marines, and National Guard, Department of Justice, U.S. Agency for International Development, and Office of Foreign Disaster Assistance. These kits are distributed to Embassies and Peace Corps Posts in over 60 countries in addition to Navy Fleet Hospitals, Army Combat and Medic Units, National Guard and Emergency Relief Programs.

In addition to providing logistical support worldwide, the SSC participates in and provides medical supply support involving high priority efforts such as international health care projects and national disaster relief support. In coordination with the Office of International Health, U.S. Agency for International Development, Federal Emergency Management Agency, and the Office of Emergency Preparedness, the Center is vital in

the medical supply support for Presidential Initiatives, National Emergencies, Disaster Relief and Medical Readiness Programs.

SSC was also the primary provider of the 2002 flu vaccine for Health and Human Services Federal Occupational Health Program, Indian Health Service and National Institutes of Health in addition to other Federal customers in Department of Defense, State Department, Peace Corps, Pacific Basin, Job Corps, and Post Office. Over 340,000 doses of flu vaccine were shipped in the first quarter of FY 2003.

The facility at Perry Point also supplies one of the newest services of the PSC, Federal Occupational Health (FOH) clinics with approximately \$4.5 million worth of supplies annually. These supplies are in the areas of pharmaceutical, nursing station supplies, minor medical devices, equipment, furniture, health education publications, canes, crutches, and forms.

Interagency agreements between SSC and various Federal agencies have resulted in several mutually beneficial working relationships. Collaborative efforts with Federal customers include the following:

In conjunction with the Department of Veterans Affairs (VA), SSC continues to serve as the unit-of-use repackager for pharmaceuticals needed by the VA's Centralized Mail Out Pharmacies (CMOPs) throughout the country. The CMOP units satisfy all the VA outpatient prescription needs. As a result of our business with the VA, SSC receives discounted prices on several pharmaceutical products on VA's National Acquisition Contracts.

The Centers for Disease Control and Prevention and D.C. Government's Division of Immunization signed interagency agreements with SSC to be their Vaccine Storage and Distribution Center. SSC receives, stores, and delivers vaccines to physicians who are enrolled in the Washington, D.C. Vaccine for Children Program.

This year SSC and the Naval Supply Systems Command Detachment updated their Memorandum of Agreement that designates the Center as the primary supplier of pharmaceuticals, medical, and diagnostic products for the Naval Fleet Hospital Program. As a result of our agreement with the U.S. Navy, additional projects were received from the Navy Fleet Hospital Program, Naval Medical Logistics Command and the U.S. Marines.

The Supply Center has three Memorandum of Agreements (MOA) with the U.S. Army Medical Materiel Agency (USAMMA) to provide materiel support for several of their programs. The first one is the Centrally Managed Potency and Dated Materiel Program Unit Deployment Package (UDP) Storage Plan. The Supply Center provides procurement, storage, inventory management and transportation of specifically identified UDP's. The second MOA was signed for the Building of Medical Assemblages. This supports the Army's Medical Department's (AMEDD) strategic level medical logistics organization whose mission is to enhance medical materiel readiness throughout the full range of military health service support missions worldwide. The third agreement

supports the Army Surgeon General's Medical Nuclear, Biological and Chemical Defense Materiel Plan. This provides the military activities with the required quantities of materiel available for a military crisis and activation that would not normally be available from a manufacturer, commercial distributor or the SSC during peacetime.

FY 2004 Objectives

AOS has established the following objectives for FY 2004:

- Develop Business Case Analysis for all product/service lines within AOS to determine best business practices. This includes reviewing all processes, method of deliveries and costs. Begin to transition those that are easily attained.
- Partner with NIH in delivering the most effective Motor Pool services by outsourcing U-Drive vehicles to a contracted rental car service allowing us to utilize vehicles on an as-needed basis.
- Look for other partnering opportunities both externally and within the Department which would bring economies of scale to our customer base.

Rationale for the Budget Request

The FY 2004 expenses for the Administrative Operations Service are estimated at \$193,855,000, an increase of \$2,064,000 over the FY 2003 estimate. This net change reflects anticipated sales increases at Perry Point, an increase in operating costs due to built-in changes for pay raise and other costs, offset by savings in administrative and overhead costs in other areas.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

FEDERAL OCCUPATIONAL HEALTH SERVICE

Authorizing Legislation - 42 USC 231

-Government Management Reform Act (GMRA)- P.L.103-356

	FY 2002 Actual	FY 2003 Estimate	FY 2004 Estimate	Increase or Decrease
Amount	\$119,885,000	\$128,761,000	\$137,943,000	\$9,182,000
FTE	83	93	93	0

FY 2004 Authorization Indefinite

Purpose and Method of Operation

The Public Health Service Act authorizes the heads of Federal agencies to provide occupational health services to their employees. Federal Occupational Health Service (FOHS) is a Service in the Program Support Center. Its mission is to work in partnership with its customers to deliver comprehensive occupational health solutions that improve the health, safety, and productivity of the Federal and military workforce.

FOHS is the largest provider of Clinical, Wellness/Fitness, Employee Assistance Program (EAP), Work/Life, and Environmental Health and Safety services to the Federal Government. FOHS has over fifty-five years of experience providing these services exclusively to Federal agencies. Currently, FOHS provides occupational health services to more than 360 Federal Government departments and agencies, reaching more than 1.5 million Federal employees. FOHS provides these services in cities and towns all across the country including some of the most remote corners of the United States. In addition, the organization's EAP and Work/Life Services are available to Federal employees and their families stationed in more than 100 countries overseas. The support and services FOHS provides enable agencies to promote health, wellness, and safe work environments for their employees as well as maintain compliance with OSHA and other Federally-mandated standards.

Organizationally, FOHS' services are managed through three Divisions: the Clinical Services Division, the Employee Assistance Program Services Division and the Environmental Health Services Division.

Clinical Services Division

The Clinical Services Division offers a wide variety of health and wellness services to keep employees healthy, productive and on the job. Clinical services are provided through a package of Basic Occupational Health Center Services or through a fee-for-service set of services that can be customized to meet the needs of its customers.

- **Basic Occupational Health Center Services** are provided through FOHS' 250 Health Centers located in or near Federal buildings throughout the United States. Services include but are not limited to:
 - Emergency Response/Walk-in Care and First Aid
 - Physician-Prescribed Services such as blood pressure and glucose monitoring, and allergy shots
 - Immunizations against influenza, pneumonia, and tetanus (when indicated)
 - Traveler's Health and Immunization Information
 - Health and Wellness Seminars and Programs on topics such as stress reduction; good nutrition and weight management; reducing cholesterol levels; breast, prostate, colorectal and skin cancer awareness, etc.
 - On-line Health Risk Appraisals
 - Health Screenings for:
 - High Blood Pressure
 - Diabetes
 - Vision
 - Tuberculosis
 - Hearing
 - Glaucoma
 - Individual Health Counseling
 - Outreach Programs
- **Fee-for-Service Services** are also provided through many of FOHS' Health Centers and through an extensive and ever-growing network of private-provider physicians and nurses. Specialized fee-for-service services include but are not limited to:
 - Medical Standards Development including the development, review and validation of medical standards for Federal law enforcement agents.
 - Physical Examinations including pre-placement, fitness-for-duty, employee and incumbent medical exams.
 - Medical Surveillance Programs including the development and implementation of both systematic and on-going assessments of employees exposed or potentially exposed to occupational hazards such as noise, asbestos, or toxic chemicals.
 - Clearance Examinations for exercise participation, fitness for duty, return to work, and respirator use.
 - Database Management including the collection, analysis and reporting of agency medical data to facilitate management of health-related requirements for medical determinations,

placement decisions, vaccination status and test results.

- Workplace Drug Deterrence Programs including:
 - Urine collection services
 - SAMHSA-certified laboratory services
 - Medical review of test results
 - Quality assurance and training
- Pre-deployment Services for military personnel. Services include immunizations (including anthrax and smallpox), medical examinations, dental examinations and restorations, as well as HIV tests.
- Automated External Defibrillator (AED) Programs including:
 - Review of existing AED Programs
 - Development of customized AED programs and protocols
 - AED Medical Director services
 - CPR and AED training and logistical support
 - Equipment selection and purchase
 - Sudden cardiac arrest event analysis
 - Critical incident stress management services
- Smoking Cessation Programs that utilize scientifically proven "quit" methods. Services include development, implementation and on-going support for individual or group "quit" programs using Nicotine Replacement Therapy (NRT) and/or behavioral change programs.
- Law Enforcement Programs - Services include development of mandatory physical fitness requirements, clearance exams, employee assistance programs, medical reviews, quality assurance programs, and database management.
- Injury Prevention and Disability Management Services including development of and support for comprehensive Injury Prevention and Disability Management (IPDM) Programs. These services are designed to provide organizations with an integrated approach to:
 - Reducing the risk of work-related injuries and illnesses
 - Reducing the associated impacts on costs and productivity
 - Helping supervisors and co-workers appropriately manage workplace accommodation and return-to-work issues, and
 - Helping the employee return to work as soon as it is safe for them to do so.

SERVICES INCLUDE:

- **WORKSITE ASSESSMENTS**
 - Safety Assessments
 - Ergonomic Assessments
 - Workplace Design Consultations

- Functional Medical Standards Review
 - Organizational Assessments
 - Post-Injury Follow-up Assessments
- HEALTH AND WELLNESS SERVICES
 - Wellness-Fitness Programs
 - Employee Assistance Programs
 - Work/Life Programs
 - TRAINING AND EDUCATION
 - Worksite Health and Safety Training
 - General Health and Disease Prevention Programs
 - MEDICAL DISABILITY MANAGEMENT
 - Case Management
 - Reasonable Accommodation Consultations
 - Light/Modified Duty Program Expert Medical Opinions
 - Return to Work Planning
- FOHS also provides a wide variety of **Wellness/Fitness Services** including:
 - Design, development, staffing and management of on-site Fitness Centers
 - Design and development of customized Wellness and Fitness Programs
 - Selection, purchase, and maintenance of fitness equipment
 - Fitness assessments and pre-participation screenings
 - Design of fitness programs and aerobics classes
 - Design and presentation of Wellness/Fitness Seminars on such topics as weight management, nutrition, and stress management
 - Promotion of Wellness/Fitness Programs

Employee Assistance Program Services Division

FOHS' EAP Services Division offers a wide variety of programs that help employees resolve personal problems that may adversely impact their work performance, conduct, health and well-being; help employees balance their work and personal lives; and help employers as employees adapt to workplace changes.

- Employee Assistance Program services are generally provided on a per-capita basis. Some services however are available on a fee-for-service basis and can be customized to meet the needs of the organization and its employees. Most services are provided by licensed professional counselors located in more than 200 counseling offices in Federal buildings across the country as well as through a vast network of "affiliate" counselors in approximately 8000 locations across the country and overseas. Counseling and referral services are available 24 hours a day, 365 days a year.

The EAP capitated program offers confidential face-to-face initial assessments, short-term counseling, referral and follow-up services, using licensed counselors, for:

- Family-relationship issues
- Workplace concerns
- Alcohol and drug problems
- Personal and emotional difficulties
- Health and behavioral issues

Other EAP services within the capitated EAP include:

- Information via an EAP Website for:
 - Educational materials, self-help strategies and other resources to help employees learn how to live healthy and work well
 - Specific information about EAP services
 - Help in preparing for sessions with a counselor
 - Self-assessments on key behavioral health topics, including depression and alcohol abuse
- Supervisor Training for supervisors, managers, employee and labor relations specialists, union officials and human resources officers on the procedures for:
 - Referring employees to the EAP
 - Crisis management
 - Appropriate documentation
 - Privacy and confidentiality
 - Employee reintegration into the work environment.
- Critical Incident Stress Management (CISM) Services using professionally trained CISM counselors to assist in the management of traumatic situations through consultations with management, and by providing defusings and debriefings.
- Employee Orientation to provide new employees with an overview of the EAP, the services offered, as well as privacy and confidentiality standards.
- Financial Services The Program offers information on a wide range of issues such as retirement planning, education funding, estate planning, and investment strategies.
- Legal Services, using licensed attorneys, practicing law in the applicable state, will provide a telephone consultation at no charge to the employee. Issues that can be addressed include:
 - Healthcare Power of Attorney
 - Living Wills
 - Housing or Real Estate matters
 - Estate Planning
 - Family law, such as divorce, child custody and child support
 - Criminal matters
- Educational Seminars on such topics as conflict resolution, substance abuse, balancing family needs, time and stress management, managing employees with

performance problems, dealing with sexual harassment, and how to cope with change.

The EAP Services Division has also developed a set of specialized programs including:

- o Organizational Development (OD) Programs Services are designed to help managers and employees improve group dynamics, communications, and their organizational culture. OD services include but are not limited to:
 - Management retreats
 - Training programs
 - Executive coaching
 - Skills development
 - Organizational change management
 - Violence prevention
 - Incidence response training
 - o Law Enforcement Assistance Programs These Programs utilize professional counselors, trained to provide services to this special needs group, to help law enforcement agency personnel and their family members cope with the unique stressors associated with this often-times dangerous and stressful occupation.
 - o Alternative Dispute Resolution (ADR) Services utilizes a network of trained and experienced ADR professionals who use a variety of ADR techniques to assist disputing parties in resolving their disagreements.
 - o Family Support Center Services are mandated by the Department of Defense and include the Family Advocacy Program, Exceptional Family Member Program, Family Member Employment Assistance, Information and Referral, Relocation Assistance Program, Outreach, and Consumer Affairs and Financial Counseling.
 - o International Employee Assistance Program Services to assist Federal employees and their families abroad. This Program includes services for U.S. citizens and local nationals as well as their family members.
- The Employee Assistance Program Services Division also offers one of the country's most comprehensive **Work/Life Programs** to Federal employees. The Program offers confidential information, referrals to qualified resources and consultation services. The Work/Life Program includes services for life events and information about:
 - Adoption
 - Becoming a Parent
 - Newborn and Child Care
 - College and Technical Schools
 - Relocation, Career Development
 - Financial Planning
 - Legal Assistance
 - Convenience Services
 - Retirement Planning

➤ Elder Care and other services for adults with disabilities and illnesses

Environmental Health Services Division

FOHS' nationwide network of environmental health and industrial hygiene specialists provide environmental, health and safety consultations and services to help Federal managers establish and maintain safe, healthy and productive work environments and to comply with OSHA and EPA regulatory compliance mandates. Services provided within this Division include but are not limited to:

- Indoor Air and Water Quality Assessments to investigate and evaluate situations where building occupants experience health problems that may be linked to air or water quality. Evaluations can include building assessments; conducting tenant meetings to identify and discuss potential problem areas; and analyzing clinical and epidemiological data to identify and address complex problems.
- Hazard Assessments to identify physical, chemical, radiological and biological stressors. FOHS experts provide personal exposure assessments and develop abatement strategies based upon a thorough evaluation of data from prior studies and/or actual sample results.
- Asbestos Detection, Monitoring and Abatement Services including development of asbestos management plans, building profiles, training, air monitoring, abatement oversight, sample analysis and record-keeping. All services are conducted in accordance with OSHA and EPA standards.
- Lead Detection, Monitoring and Abatement Services to comply with Title X of the Housing and Community Development Act of 1992 (Section 403). FOHS can help develop lead abatement programs, design lead management plans and provide lead abatement oversight. In addition, FOHS' industrial hygienists can educate Federal managers and employees about the hazards of lead in drinking water, working safely with lead, and the safe removal of lead-based paint.
- Safety Assessments and Training to help managers improve their organization's safety and health programs and to educate managers about the importance of and requirements for ensuring that employees are safe and healthy in the workplace.
- Environmental Surveys to help organizations meet the requirements of the Resource Conservation and Recovery Act, the Comprehensive Environmental Response Compensation and Liability Act as well as the Superfund Amendments and Reauthorization Act.
- Personal Protective Equipment (PPE) Program Development and Implementation including a respiratory protection program as required in 29CFR 1910.132 and 1910.139. FOHS' experts can help develop or suggest improvements to PPE Program elements including hazard assessments and fit testing.
- Hearing Conservation Consultations and Assessments to assist in the implementation of agency-specific hearing conservation programs. In accordance with OSHA's standard 1910.95, FOHS will provide noise exposure assessments, noise exposure monitoring, octave

band analyses, and noise engineering surveys.

- Hazard Communication Program Development and Implementation to help agency managers meet the requirements of OSHA's Hazard Communication Standard. FOHS' environmental health professionals can conduct hazard communication training for employees, develop inventories of hazardous materials, provide material safety data sheets, conduct program evaluations and develop hazardous material control plans.
- Emergency Response Plan Development and Training including the development of comprehensive safety and health programs, employee and supervisory emergency response training, and the development and implementation of emergency response plans.
- Food Sanitation and Service Inspections to ensure compliance with all applicable FDA regulations. Inspections ensure that food preparation, storage and service meet the necessary requirements to ensure its safety.
- Ergonomics Assessments and Program Development to help managers prevent work-related injuries and address workplace injury risk factors that help employees stay healthy and on the job. Ergonomic Program elements include:
 - Consultations on the selection and procurement of workstation equipment and furniture.
 - Individual workstation evaluations
 - Training seminars and on-line training
 - Assisting with reasonable accommodation requests and return to work issues
 - Recommendations for space planning and appropriate workstation and computer setups
 - Converting generic job descriptions to functional job requirements that identify physical demands of the job tasks
 - Recommendations for overall compliance with OSHA's ergonomics guidelines including assistance in developing written policies, hazard reporting, job analyses, training requirements and management procedures.
- FOHS' Environmental Health Services Division also manages three fully-equipped and **accredited reference laboratories**. These state-of-the art laboratories offer both sampling and analytical support services and specialize in industrial hygiene, environmental, microbiological, as well as asbestos and other fine particle analyses. Analyses are conducted for heavy metals, regulated chemicals, fungi, molds, indoor allergens, water-borne contaminants, asbestos and other fine particles.

FY 2004 Objectives

- Increase the number of Federal employees covered by our basic clinical occupational health program from 226,000 (the FY2002 population) to at least 235,000.

- Increase the number of billable hours of environmental health consultation and services to Federal agency customers from 165,000 hours to 182,000 hours.
- Add 100,000 Federal employees to the population covered by FOHS' employee assistance and work-life programs, thereby increasing program coverage from 1,300,000 employees to 1,400,000 employees.
- Maintain a 95% initial customer satisfaction rate, and resolve all resolvable customer satisfaction issues.

Rationale for the Budget Request

FOHS provides occupational health consultation and services to other Federal agencies through interagency agreements. Costs of services are fully reimbursable and, therefore, FOHS does not receive appropriated funds. The budget request of \$137,943,000 is an increase of \$9,182,000 over FY 2003 and reflects an anticipated increase of customer services in FY 2004, as well as covering built-in pay raises and other increases which are offset by savings in administrative and overhead costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER

Detail of Full-Time Equivalent Employment (FTE)

	2002 Actual	2003 Estimate	2004 Estimate
Human Resources Service.....	264	264	264
Commissioned Personnel Service.....	103	103	103
Financial Management Service.....	243	258	258
Administrative Operations Service.....	428	402	402
Federal Occupational Health.....	83	93	93
Office of the Director.....	27	28	28
Freedom of Information.....	<u>3</u>	<u>3</u>	<u>3</u>
Total, FTEs.....	1,151	1,151	1,151

Average GS Grade

2001.....	10.56
2002.....	10.66
2003.....	10.71
2004.....	10.75

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROGRAM SUPPORT CENTER
Detail of Positions

	2002 Actual	2003 Estimate	2004 Estimate
ES-4.....	1	1	1
ES-3.....	2	2	3
ES-2.....	4	4	4
ES-1.....	1	1	0
Subtotal.....	8	8	8
Total - ES Salary.....	\$1,067,498	\$1,099,523	\$1,132,509
GS-15.....	49	51	53
GS-14.....	129	133	135
GS-13.....	200	206	208
GS-12.....	176	178	180
GS-11.....	90	92	95
GS-10.....	3	5	7
GS-09.....	81	79	75
GS-08.....	43	43	43
GS-07.....	78	80	82
GS-06.....	41	40	38
GS-05.....	60	55	50
GS-04.....	40	35	33
GS-03.....	16	12	10
GS-02.....	9	7	7
GS-01.....	1	0	0
Subtotal.....	1,016	1,016	1,016
CO-07.....	1	1	1
CO-06.....	31	32	33
CO-05.....	24	26	27
CO-04.....	18	20	21
CO-03.....	6	4	2
CO-02.....	4	2	1
CO-01.....	1	0	0
Subtotal.....	85	85	85
Wage Graded			
07.....	1	1	1
06.....	14	15	17
05.....	7	9	9
04.....	19	16	14
03.....	1	1	1
02.....	0	0	0
Subtotal.....	42	42	42
Total FTE usage, end of year.....	1,151	1,151	1,151
Average ES level.....			2.63
Average ES salary.....			\$141,564
Average GS level.....			10.75
Average GS salary.....			\$70,267
Average Commissioned Officer grade.....			4.85
Average Commissioned Officer salary.....			\$89,070
Average Wage Graded grade.....			4.88
Average Wage Graded salary.....			\$34,391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

<u>FY 2004 Budget</u>	<u>Page</u>
Appropriation Language	50
Amounts Available for Obligation	51
Summary of Changes	52
Budget Authority by Activity	53
Budget Authority by Object	54
Authorizing Legislation	55
Appropriations History Table	56
Justification:	
A. Account Summary	57
B. General Statement	57
C. Retirement Payments	58
D. Survivors' Benefits	59
E. Medical Care	60

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, for payments under the Retired Serviceman's Family Protection Plan and Survivor Benefit Plan, and for medical care of dependents and retired personnel under the Dependent's Medical Care Act (10 U.S.C. ch. 55 and 56), such amounts as may be required during the current fiscal year.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Amounts Available for Obligation

	FY 2002 <u>Actual</u>	FY 2003 <u>Appropriation</u>	FY 2004 <u>Estimate</u>
Appropriation	\$273,478,736	\$285,486,000	\$303,392,000
Total obligations	\$273,478,736	\$285,486,000	\$303,392,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Summary of Changes

2003 Appropriation	\$285,486,000
2004 Request	<u>303,392,000</u>
Net change	+17,906,000

	FY 2003 Current		Change from Base	
	<u>Estimate Base</u>			
	FTE	BA	FTE	BA
Changes:				
1. Annualization of the FY 2003 COLA, 4.5% COLA in FY 2004, and for the projected net increase of retirees during FY 2004	—	\$218,984,000	---	+\$15,016,000
2. Will only cover medical benefits for Officers under age 65. Costs do include a projected increase of 3.8% in medical care costs for these Officers.	—	52,400,000	---	+1,991,000
3. Annualization of the FY 2003 COLA, 4.5% COLA in FY 2004, and projected net increase in average costs per survivor in FY 2004	—	14,102,000	---	+899,000
Net change			---	+\$17,906,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Activity

	FY 2002 <u>Actual</u>	FY 2003 <u>Appropriation</u>	FY 2004 <u>Estimate</u>
Retirement payments	\$204,224,261	\$218,984,000	\$234,000,000
Survivors' benefits	13,216,357	14,102,000	15,001,000
Medical care	<u>56,038,118</u>	<u>52,400,000</u>	<u>54,391,000</u>
Total	\$273,478,736	\$285,486,000	\$303,392,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Budget Authority by Object

	FY 2002 <u>Actual</u>	FY 2003 <u>Appropriation</u>	FY 2004 <u>Estimate</u>	Increase/ <u>Decrease</u>
Benefits for former personnel	\$217,440,618	\$233,086,000	\$249,001,000	+\$15,915,000
Other services	<u>56,038,118</u>	<u>52,400,000</u>	<u>54,391,000</u>	<u>+1,991,000</u>
Total budget authority by object	\$273,478,736	\$285,486,000	\$303,392,000	+\$17,906,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Authorizing Legislation

	FY 2003 Amount <u>Authorized</u>	FY 2003 <u>Appropriation</u>	FY 2004 Amount <u>Authorized</u>	FY 2004 <u>Estimate</u>
1. Retirement payments Chapter 6A of Title 42, U.S.C.	Indefinite	\$218,984,000	Indefinite	\$234,000,000
2. Survivors' benefits Chapter 73 of Title 10, U.S.C.	Indefinite	14,102,000	Indefinite	15,001,000
3. Medical care Chapter 55 and 56 Of Title 10 U.S.C., P.L. 89-614; P.L.106- 398; P.L.107-107.	Indefinite	52,400,000	Indefinite	54,391,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Appropriations History Table

<u>Year</u>	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1992	\$134,674,000	\$134,674,000	\$134,674,000	\$123,189,000
1993	140,762,000	140,762,000	140,762,000	140,463,000
1994	153,060,000	153,060,000	153,060,000	147,191,000
1995	159,321,000	159,321,000	159,321,000	144,370,000
1996	166,925,000	166,925,000	166,925,000	154,715,000
1997	178,635,000	178,635,000	178,635,000	179,008,000
1998	190,739,000	190,739,000	190,739,000	190,996,000
1999	201,635,000	201,635,000	201,635,000	200,870,805
2000	214,905,000	214,905,000	214,905,000	201,842,168
2001	219,772,000	219,772,000	219,772,000	245,956,147
2002	242,577,000	242,577,000	242,577,000	273,478,736
2003	251,039,000	251,039,000	251,039,000	285,486,000
2004	303,392,000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Retirement Pay and Medical Benefits for Commissioned Officers

Justification

	FY 2002 <u>Actual</u>	FY 2003 <u>Appropriation</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Retirement payments	\$204,224,261	\$218,984,000	\$234,000,000	+\$15,016,000
Survivors' benefits	13,216,357	14,102,000	15,001,000	+899,000
Medical care	<u>56,038,118</u>	<u>52,400,000</u>	<u>54,391,000</u>	<u>+1,991,000</u>
Total budget authority	\$273,478,736	\$285,486,000	\$303,392,000	+\$17,906,000

General Statement

This appropriation provides for retirement payments to Public Health Service (PHS) officers who are retired for age, disability, or a specified length of service as well as for payments to survivors of deceased officers who had elected to receive reduced retirement payments.

This account also funds the provision of medical care to active duty and retired members of the PHS Commissioned Corps, and to dependents of active duty, retired and deceased members of the PHS Commissioned Corps.

The FY 2004 request is a net increase of \$17,906,000 over the FY 2003 level. This amount reflects increased medical benefits costs, an annualization of amounts paid to retirees and survivors in FY 2003, and a net increase in the number of retirees and survivors during FY 2003. The budget request includes cost-of-living adjustment (COLA) of 4.5 percent.

Retirement Payments

Authorizing legislation - Chapter 6A of Title 42 U.S.C.

<u>FY 2002</u> <u>Actual</u>	<u>FY 2003</u> <u>Appropriation</u>	<u>FY 2004</u> <u>Estimate</u>	<u>Increase or</u> <u>Decrease</u>
\$204,224,261	\$218,984,000	\$234,000,000	+\$15,016,000

2004 Authorization Indefinite

Purpose and Method of Operation

The purpose of this activity is to provide mandatory payments to Commissioned Officers of the Public Health Service who have been retired for age, disability or specified length of service.

Funding levels for the past five fiscal years were as follows:

1999	\$159,457,665
2000	157,548,454
2001	193,942,280
2002	204,224,261
2003	218,984,000

Rationale for the FY 2004 Budget Request

The FY 2004 request of \$234,000,000 is an increase of \$15,016,000 over the FY 2003 level and will support payments to an estimated 4,463 annuitants. The increase will fund the annualization costs of the FY 2003 COLA, an FY 2004 COLA of 4.5 percent, and the projected net increase of 108 retirees during FY 2004.

The FY 2004 estimates are based on payments to the following number of retirees:

<u>Period Ending</u>	<u>Total</u>	<u>Net</u> <u>Increase</u>
September 30, 2002, (act.)	4,247	149
September 30, 2003, (est.)	4,355	108
September 30, 2004, (est.)	4,463	108

Survivors' Benefits

authorizing legislation - Chapter 73 of Title 10 U.S.C.

<u>FY 2002</u> <u>Actual</u>	<u>FY 2003</u> <u>Appropriation</u>	<u>FY 2004</u> <u>Estimate</u>	<u>Increase or</u> <u>Decrease</u>
\$13,216,357	\$14,102,000	\$15,001,000	+\$899,000

004 Authorization Indefinite

Purpose and Method of Operation

This activity provides for the payment of annuities to survivors of retired officers who had elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan and Survivor's Benefit Plan. This program is financed by the Federal Government although deductions are made in the retirement payments to the officers who elect the option of survivors' benefits.

Pending levels for the past five years were as follows:

1999	\$11,582,239
2000	10,791,118
2001	11,336,715
2002	13,216,357
2003	14,102,000

Rationale for the FY 2004 Budget Request

The FY 2004 request of \$15,001,000 is an increase of \$899,000 from the FY 2003 level and will provide payments for an estimated 636 annuitants. This amount includes funds for the annualization costs of the FY 2003 COLA and the FY 2004 COLA of 4.5 percent.

The FY 2004 estimates are based on payments to the following numbers of annuitants:

<u>Period Ending</u>	<u>Total</u>	<u>Net</u> <u>Increase</u>
September 30, 2002, (act.)	612	2
September 30, 2003, (est.)	624	12
September 30, 2004, (est.)	636	12

ical Care

orizing legislation - Chapter 55 of Title 10 U.S.C.; P.L. 106-398; and P.L. 107-107.

FY 2002 <u>Actual</u>	FY 2003 <u>Appropriation</u>	FY 2004 <u>Estimate</u>	Increase or <u>Decrease</u>
\$56,038,118	\$52,400,000	\$54,391,000	\$1,991,000

Authorization Indefinite

ose and Method of Operation

program provides for the cost of medical care rendered in non-Federal and in uniformed service facility duty and retired PHS commissioned officers and dependents of eligible personnel.

activity fulfills the mandatory medical care obligations of the Public Health Service to Commissioned officers and their dependents. Medical care to eligible beneficiaries is authorized under the Dependents' Medical Care Act, as amended by P.L. 89-614, which allows for an expanded and uniform program of medical care to active duty and retired members of the uniformed services, and dependents of active duty, retired and deceased members. Health care provided in a uniformed service facility is billed directly to the Public Health Service by that organization. When medical care is provided to dependents or retirees in a private facility, the Uniformed Services Health and Medical Program of the Uniformed Services (TRICARE) acts as the Government's agent for payment and, in turn, bills the Public Health Service for the services rendered. In addition, medical care is arranged for active duty officers who are not stationed in an area accessible to uniformed service facilities.

legislation is being proposed to allow for the adjustment of accrual amounts that uniformed services members currently pay into the Department of Defense Uniformed Service Retiree Health Care Fund for Medicare-eligible beneficiaries. The adjustment would allow accrual rates to reflect more accurately the all-officer composition of the Public Health Service Commissioned Corps. The FY 2004 budget includes \$13 million difference between the rate under existing law and the rate that would result from the proposal.

ing and beneficiary levels for the past five years were as follows:

	Total <u>Funding Level</u>	<u>Beneficiaries</u>
1999	\$27,578,901	27,500
2000	32,174,596	27,500
2001	39,325,152	27,500
2002	56,038,118	27,500
2003	52,400,000	27,500

rationale for FY 2004 Budget Request

A request of \$54,391,000 will provide medical care for under age 65 beneficiaries. The FY 2004 request reflects increases in the cost of drugs and inpatient and outpatient care for all beneficiaries in Federal and non-Federal facilities. The request also includes the costs of the proposal to allow for adjustment of curricular rates for Medicare-eligible beneficiaries.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROGRAM SUPPORT CENTER

FINAL FY 2004 GPRA ANNUAL PERFORMANCE PLAN
REVISED FINAL FY 2003 GPRA ANNUAL PERFORMANCE PLAN
FY 2002 GPRA ANNUAL PERFORMANCE REPORT

January 2003



TABLE OF CONTENTS

•	Executive Summary	65
•	Program Support Center Mission.....	67
•	Overview of Plan and Performance Report	67
 I. Overview of Performance Measurement		
•	Performance Measurement.....	69
•	Report/Plan Road Map	69
•	Budget Linkage	73
 II. Measure-by-Measure Performance		
•	Introduction	74
•	Customer Service	75
•	Financial Resource Management	88
•	Business Strategy and Innovation	92
•	Employment Management and Development	96
 III. Appendix to the Performance Plan		
•	Linkage to HHS and Agency Strategic Plans	102
•	Changes/Improvements Over Previous Year	103
•	Partnerships & Coordination.....	106
•	Data Verification & Validation	107
•	Performance Measurement Linkages	108

EXECUTIVE SUMMARY

The Program Support Center's Performance Plan and Report reviews past years and looks to the future, reflecting steady progress in defining and delivering quality, competitive Government support products and services to our customers.

The PSC provides Federal government administrative and logistical support services to HHS and other Federal agencies. Services include: acquisition and contract management services; medical supply repackaging and distribution services; building and security services; Federal occupational health services; personnel and payroll services; facilities and materiel management services; telecommunications services; accounting and financial management services; and information technology services. The PSC is committed to earning and maintaining a reputation as a quality, responsive, value-oriented, technically competent, and customer-service oriented organization.

PSC's FY 2002 accomplishments include:

- Achieved unqualified audit opinions for all six customer OPDIVs in the FY 2001 audits of financial statements and there were no new material weaknesses in all six of those audits.
- Developed a comprehensive competitive sourcing plan in accordance with the President's Management Agenda. The FY 2002 competitive sourcing goal of 5% was exceeded.
- Began and substantially completed development of a new PSC billing system in FY 2002. The PSC Revenue, Invoicing, and Cost Estimation System (PRICES) was delivered and made operational on November 15, 2002.
- The Payment Management System team processed more than 300,000 payments totaling more than \$244B to grantees while collecting approximately \$10M in interest earned on Federal Funds on deposits with grantees.
- Brought the HHS Department on-line to the new state-of-the-art PeopleSoft personnel system. The PeopleSoft system was fully deployed in October 2002, four months ahead of schedule.
- Successfully implemented a number of best practices and state-of-the-art automated tools such as Help Tool, Application Messaging, and People Tools to enhance the HR process and improve customer relations.
- Streamlined our work structures and processes to increase direct access of customers to service decision points.
- Conducted a review of our business practices and began preparation of business cases that will recommend actions to refine, improve or change our business practices.

- FOHS grew its business by 17% in the year, primarily due to huge demands for services from its customers engaged in National and Homeland Defense.

The Program Support Center's vision is to be a customer-driven organization that provides high quality products and outstanding services that will earn us a service delivery reputation that is second to none.

PSC Performance Report Summary

The following chart shows a summary of the PSC measures from FY 1999 to the present

Fiscal Year	Measures in Plan	Results Reported	Results Met	Unreported
1999	40	40	36	0
2000	42	42	28	0
2001	42	42	30	0
2002	44	31	27	13
2003	21			
2004	19			

Point of Contact:

Ms. Jerrilyn Anderson
Office of Budget and Management
Program Support Center
301-443-1486

Program Support Center Mission

The Program Support Center provides customer-focused administrative services and products for the Department of Health and Human Services.

The PSC is charged with providing a full range of support services to all components of the HHS focusing primarily on products and services in the following areas:

- Human Resources
- Health Resources
- Administrative Services
- Financial Management
- Information Technology

It is the intent of the PSC to provide support to assist and enable the Department to accomplish its mission. The PSC does not directly enhance the health and well being of Americans, rather it takes great pride in providing support services to the HHS agencies allowing them to focus on their core missions.

HHS' Mission: To enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services.

Overview of Plan and Performance Report

In 2001 the Program Support Center identified four core goals that are illustrative of the outcomes the PSC seeks to achieve. Each of the goals has specific objectives which support and reinforce the President's Management Agenda, the Secretary's "One Department," and the HHS "10 and 10" goals. The core goals are:

Customer Service
Financial Resource Management
Business Strategy and Innovation
Employee Management and Development

The PSC Performance Plan and Report are organized around these goals. Under each core goal we have developed strategic management objectives that state the outcomes we seek to achieve. Under the objectives are the specific measures that will help us to achieve the objectives and goals. Part II of this document provides our goals, objectives, measures and accomplishments.

To accomplish the PSC mission, we have set forth values and guiding principles that describe how we approach performing our mission and how we will proceed toward realizing our vision.

Values

- Customer Satisfaction
- Competence
- Candor
- Commitment
- Communication

Guiding Principles

1. **Customer Focus**
We are committed to building partnerships with our customers that will enable us to deliver quality products, excellent service and meet their evolving program support needs.
2. **Workforce Excellence**
We are committed to developing a workforce comprised of talented employees who have the proper tools, training, and incentives to foster a commitment that guarantees outstanding product and service quality.
3. **Cost Management**
We are committed to ensuring the "price is right" by operating a "fee-for-service" business based upon cost control, economies of scale and market-driven prices.
4. **Best Business Practices**
We are committed to exploring new ideas and delivery methods through collaboration with our customers, ongoing continuous process improvement, and reengineering.
5. **Communication**
We are committed to engaging in ongoing dialogue with our customers, seeking honest feedback and constructive criticism to enable us to improve our product and service quality and reduce costs.

PART I - OVERVIEW OF PERFORMANCE MEASUREMENT

Performance Measurement

One of the most challenging aspects to instituting a system of strategic and operational performance measures is to ensure that the organization does not single out a particular measure to the exclusion of all others. Towards that end, and to ensure that the goals and objectives are clearly heard throughout the entire organization, the PSC has adopted the private sector model of a balanced scorecard to ensure complementary measures are achieved. In order to achieve the PSC's mission, the PSC has set into place the following set of four core goals:

- **Customer Service**
- **Financial Resource Management**
- **Business Strategy and Innovation**
- **Employee Management and Development**

With each of these goals defined, specific "strategic management objectives" and performance goals and targets were established.

Performance measures provide the feedback necessary to determine if we are making progress toward achieving our goals and objectives. Specific targets have been developed for each goal. All of the targets are crafted to advance our commitment to earning and maintaining a reputation as a quality, responsive, value-oriented, technically competent, and customer-service oriented organization.

The PSC Government Performance and Results Act (GPRA) Plan reflects these PSC core goals, strategic management objectives and performance goals. Successful accomplishment of the goals and objectives will ensure achievement of our vision and mission.

Report/Plan Road Map

The PSC has identified five strategic management objectives that support the PSC's four core goals. The Plan is organized by core goal and the related strategic management objective(s), with performance goals and targets for each objective. Detailed information regarding these goals may be found in the chart in section A.2., in the Appendix. The numbers in parentheses after certain goals below reflect the goal number in the FY 2002 Plan, while the numbers in the brackets refer to the fiscal year for which the goal applies.

Core Goal I. - Customer Service

Strategic Management Objective 1 - Improve PSC Services While Controlling Costs

- 1.1. Provide management reports that provide relevant and accurate cost, revenue, and Net Operating Result (NOR) information to managers by organization, service, customer, and time period [FY 03, 04 goal]
- 1.2. Implement Change Management techniques across PSC to align behaviors with strategy [FY 03, 04 goal]

- 1.3. Develop a Customer Relations Management Program -- Implement one stop shop approach, centralize agreements, sponsor focus groups and customer visits [FY 03, 04 goal]
- 1.4. Achieve at least 5 of 8 of the following acquisition standards each year: (2) [FY 02 goal]
 - a. Award in 5 working days from receipt of an acceptable RFC 95% of Micro purchases (Simplified Acquisitions under \$2,500)
 - b. Award in 15 working days from receipt of an acceptable RFC 95% of simplified acquisitions (less complex under \$100,000)
 - c. Award in 45 working days from receipt of an acceptable RFC 95% of simplified acquisitions (complex)
 - d. Award in 90 days from receipt of an acceptable RFC 95% of sealed bid acquisitions
 - e. Award in 90 days from receipt of an acceptable RFC 95% negotiated sole source acquisitions
 - f. Award in 135 days from receipt of an acceptable RFC 95% negotiated competitive acquisitions (non-complex)
 - g. Award in 175 days from receipt of an acceptable RFC 95% negotiated competitive acquisitions (complex)
 - h. Expand acquisitions customer base
- 1.5. Increase use of performance-based contracts; award at least 20% of new eligible PSC service contracts over \$100K as performance based (37) [FY 02, 03, 04 goal]
- 1.6. Achieve performance standards every year at Supply Service Center (3) [FY 02 goal]
 - a. Achieve a 95% Fill Rate standard for the SSC
 - b. Achieve a .5% Delivery Discrepancy Rate for the SSC
 - c. Achieve a .05% Damaged Shipment Rate for the SSC
 - d. Achieve a .4% Shipping Accuracy Rate for the SSC
 - e. Achieve a 95% Rate in Meeting the Order Turn-Around Time Standard
 - f. Achieve a 95% Customer Satisfaction Rate with SSC Services
- 1.7. Increase or maintain level of Building Management service calls corrected during first response. (11) [FY 02 goal]
- 1.8. Properly addressed incoming and outgoing mail will be processed within one day. Shipments received with special agreements, e.g., large mailings, will be processed within 5 days over 97% of the time. (12) [FY 02 goal]
- 1.9. FOH -- Eliminate Barriers to Care--Increase Access Points
Clinical Service: Provide needed basic clinical services to Federal employees (13) [FY 02 goal]
- 1.10. Employee Assistance Program: Provide employee assistance services (14) [FY 02, 03, 04 goal]
- 1.11. FOH – Environmental Health Services: Increase the hours of environmental health services provided and billed to customers (41) [FY 02 goal]
- 1.12. Reduce the unit core cost of personnel/payroll services to PSC customers (33) [FY 02 goal]
- 1.13. Reduce or maintain the unit cost of forms and publications distribution service for HHS customer products (34) [FY 02 goal]
- 1.14. Maintain unit cost per line (TIP) (35) [FY 02 goal]
- 1.15. Refer eligible Health Professions debt to the Office of the Inspector General for exclusion from participation in Medicare [FY 03, 04 goal]

- 1.16. Continue centralization of hardware, software and support resources to realize greater gains in managing support activities and taking advantage of economies of scale [FY 03, 04 goal]

Strategic Management Objective 2 - Maximize Opportunities to Improve Customer Satisfaction Levels

- 2.1. Distribute PSC comment cards and evaluate monthly and conduct a PSC-wide customer satisfaction survey annually (1) This has been revised to include the PSC comment cards. [FY 02, 03, 04 goal]
- 2.2. Customer Service Training --Train employees to level of performance that customer satisfaction is achieved the first time [FY 03, 04 goal]
- 2.3. Provide customers with on-line invoicing and on-line viewing of bills that provide customers with an accurate, clear, and concise detailing of service provided, with drill-down capability [FY 03, 04 goal]
- 2.4. Assure Quality of Care – Improve Customer/Patient Satisfaction. Improve total customer satisfaction among Federal agencies served (15) [FY 02, 03 goal]

Core Goal II. – Financial Resource Management

Strategic Management Objective 3 - Improve PSC Financial Performance and Assure Budget and Performance Integration

- 3.1. Achieve Unqualified (clean) Audit Opinions for the PSC and Its Customers (17-22) [FY 02, 03, 04 goal]
- 3.2. Reduce PSC and Customer Material Weaknesses (MW) or Reportable Conditions (RC) (23-28) [FY 02, 03, 04 goal]
- 3.3. Implement automated costing model to allow proper alignment of fully burdened costs to the proper product/service and integration of product costs to the budget [FY 03, 04 goal]
- 3.4. Review and negotiate 85% indirect cost rate proposals within six months of receipt (29) [FY 02 goal]
- 3.5. Exceed the OMB objective of 95% of vendor invoices paid on time (31) [FY 02 goal]
- 3.6. Refer delinquent debts to the Treasury Offset Program (TOP) within required time frame (32) [FY 02 goal]
- 3.7. Reduce erroneous payments to recipients of Government funds (16) [FY 02 goal]

- 3.8. Implement Results Oriented Management -- Create performance contracts for all PSC supervisors and managers that tie their performance to the PSC strategic plan [FY 03 goal]

Core Goal III. - Business Strategy and Innovation

Strategic Management Objective 4 - Optimize E-Gov Opportunities and Ensure Competitive Sourcing Compliance

- 4.1. Partner with other Federal agencies to provide services [FY 03, 04 goal]
- 4.2. Increase non-waivered electronic disbursements (30) [FY 02 goal]
- 4.3. Expand on-line procurements and E-government services; post all synopses over \$25K on Governmentwide Web site (38) [FY 02 goal]
- 4.4. Payment management -- increase number of recipient organizations reporting electronically (39) [FY 02 goal]
- 4.5. Implement Human Resources automation tools [FY 03, 04 goal]
- 4.6. Replace present Legacy Human Resources System with a state-of-the-art HR system (40) [FY 02, 03, 04 goal]
- 4.7. Develop and implement a three-year competitive sourcing plan and complete competitive sourcing studies for commercial activities of the PSC according to OMB goals and based on the PSC FAIR inventory for FY 00 (36) [FY 02, 03, 04 goal]

Core Goal IV. - Employee Management and Development

Strategic Management Objective 5 - Managing Human Capital Strategically

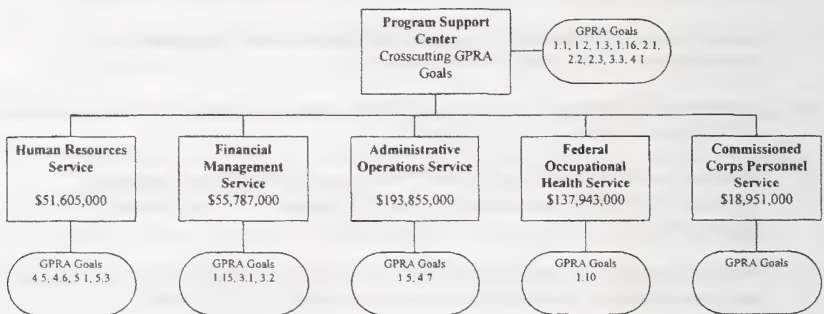
- 5.1. Implement workforce strategies and systems to recruit and retain [FY 03, 04 goal]
- 5.2. Achieve overall increase in employee satisfaction PSC-wide (43) [FY 02 goal]
- 5.3. Cross-train/re-train PSC staff to accommodate those impacted by outsourcing, consolidation or restructuring [FY 03, 04 goal]
- 5.4. Exceed the OPM timeliness requirement of 80% of payroll separation processing actions to OPM within 30 days (4) [FY 02 goal]
- 5.5. Position classification services: develop 95% of position descriptions, evaluation statements and supporting documents within 2-10 work days (routine actions) (5) [FY 02 goal]
- 5.6. Personnel staffing services: Prepare 90% of vacancy announcements within 2-3 working days upon receipt of the classified position description (6) [FY 02 goal]

- 5.7. Executive recruitment: 90% of vacancy announcements will be completed 2-10 work days upon receipt of classified position description (7) [FY 02 goal]
- 5.8. Personnel processing services: 90% of pay documents will be processed within the pay period (unless the last Friday) (8) [FY 02 goal]
- 5.9. 95% of all commissioned corps on-line applicants to be personally contacted, oriented, and educated on the Corps within 3 working days and given access to entire application (9) [FY 02 goal]
- 5.10. 95% of all commissioned corps applicants will be issued orders within 5 working days after hiring agency issues a form PHS-1662 (10) [FY 02 goal]
- 5.11. Delayer and streamline PSC; decrease supervisor to employee ratio (42) [FY 02 goal]
- 5.12. Reduce incidents of workplace violence, thefts, and threats to Federal property (44) [FY 02 goal]

Budget Linkage

By its very nature, the PSC is a performance-driven organization. The budget of the PSC is approved by the HHS Service and Supply Fund Board of Directors comprised of senior managers of HHS customer organizations. The PSC prepares its budgets based upon a projected business base, and collects revenue based upon actual performance of services and goods. The PSC develops a budget and closely tracks revenues and expenditures in an effort to maintain a break-even position. The PSC expenditures grow or contract based upon fluctuations in demand for services. Services are provided in four broad business areas: human resources, including civil service and commissioned corps; financial management; administrative operations; and, Federal occupational health. Performance measures have been developed for the major products and services offered by the PSC. The following chart shows the PSC Services with each total budget and the GPRA goals associated with each organization for FY 04; all Services contribute to the crosscutting goals.

FY 04 PSC Budget and GPRA Goals



PART II. Measure-by-Measure Performance

Introduction

The PSC subscribes to the theory that you “can’t manage what you can’t measure.” Measuring our progress and performance is an essential part of our strategic visioning and planning process. The FY 03 and FY 04 performance goals and targets are directly linked to the strategic management objectives and the core goals. Although we are moving toward a PSC-wide approach to our GPRA performance goals, each of the PSC Services has goals and targets that mirror and complement the overall PSC goals, whether or not they appear in the GPRA Plan, and all employees’ performance plans will reflect the goals and objectives.

Successful accomplishment of these goals and objectives is the focus of our activity at all levels in the PSC. The objectives are broad and encompass nearly every operation of the PSC. Our day-to-day work will ensure the achievement of these objectives.

Many of the FY 02 goals and targets, which are largely service area outputs, have been dropped from these Plans as we are concentrating on PSC-wide and outcome oriented goals. The FY 02 data that is not available in this submission will be provided in subsequent submissions as it becomes available. Although many of the FY 02 goals will no longer be reported in GPRA, we will continue to track those, and many others, through our performance management plans. We have gone from 44 goals in FY 02 to 21 in FY 03 and 19 in FY 04.

The reference column in the performance tables indicate which goals are Presidential Management Agenda goals “” and which are “One HHS” Department-wide Management Objectives, e.g., “.

I. - Customer Service – Continue to develop and manage quality programs, activities, and functions of the PSC at reasonable costs in support of HHS missions, legislative mandates and policy directives.

CUSTOMER SERVICE			
Performance Goals	Targets	Actual Performance	Reference B= Budget P= Performance Plan
Strategic Management Objective 1 – Improve PSC Services While Controlling Costs			
1.1. Provide management reports that provide relevant and accurate cost, revenue, and Net Operating Result (NOR) information to managers by organization, service, customer, and time period	FY 04: Provide accurate management reports for 100% of the PSC services FY 03: Provide accurate management reports covering at least 75% of the PSC services	FY 04: FY 03:	P 79 
1.2. Implement Change Management techniques across PSC to align behaviors with strategy	FY 04: Train 100% of employees in strategic goals, vision, and values FY 03: Work with executive team and mid-level managers to align their perspectives with the strategic goals, vision and values	FY 04: FY 03:	P 79-80
1.3. Develop a Customer Relations Management Program -- Implement one stop shop approach, centralize agreements, sponsor focus groups and customer visits	FY 04: 100% implemented FY 03: 50% implemented	FY 04: FY 03:	P 80

Performance Goals	Target	Actual Performance	
1.4. Achieve at least 5 of 8 of the following acquisition standards each year: a. Award in 5 working days from receipt of an acceptable RFC 95% of Micro purchases (Simplified Acquisitions under \$2,500) b. Award in 15 working days from receipt of an acceptable RFC 95% of simplified acquisitions (less complex under \$100,000) c. Award in 45 working days from receipt of an acceptable RFC 95% of simplified acquisitions (complex) d. Award in 90 days from receipt of an acceptable RFC 95% of sealed bid acquisitions e. Award in 90 days from receipt of an acceptable RFC 95% negotiated sole source acquisitions f. Award in 135 days from receipt of an acceptable RFC 95% negotiated competitive acquisitions (non-complex) g. Award in 175 days from receipt of an acceptable RFC 95% negotiated competitive acquisitions (complex) h. Expand acquisitions customer base	FY 02: 5 of 8 standards achieved	FY 02: 2 of 7 achieved; 1-none processed. (not met) a. 70% (not met) b. 74% (not met) c. 93% (not met) d. none processed e. 87% (not met) f. 100% (met) g. 86% (not met) h. 1 new customer (met) FY 01: 7 of 8 achieved	B 29-36 P 80
1.5. Increase use of performance-based contracts; Award at least 20% of new eligible PSC service contracts over \$100K as performance based	FY 04: Increase over FY 03 FY 03: Increase over FY 02 FY 02: Increase over FY 01	FY 04: FY 03: FY 02: 50% (met) FY 01: 33%	B 29-36 P 80 
1.6. Achieve performance standards every year at Supply Service Center: a. Achieve a .95% Fill Rate standard for the SSC b. Achieve a .5% Delivery Discrepancy Rate for the SSC c. Achieve a .05% Damaged Shipment Rate for the SSC d. Achieve a .4% Shipping Accuracy Rate for the SSC e. Achieve a 95% Rate in Meeting the Order Turn-Around Time Standard f. Achieve a 95% Customer Satisfaction Rate with SSC Services	FY 02: 4 of 6	FY 02: 6 of 6 (met) a. 96% (met) b. .16% (met) c. .04% (met) d. .12% (met) e. 95% (met) f. 95% (met) FY 01: 6 of 6 (met)	B 29-36 P 80-81

Performance Goals	Measures	Performance	Reference
1.7. Increase or maintain level of Building Management service calls corrected during first response	FY 02: Increase over FY 01 FY 01: Increase over FY 00 FY 00: Increase over FY 99 FY 99: Increase over FY 98	FY 02: 96% (met) FY 01: 95% (met) FY 00: 94% (not met) FY 99: 94% (met) FY 98: 91%	B 29-36 P 81
1.8. Properly addressed incoming and outgoing mail will be processed within one day. Shipments received with special agreements, e.g., large mailings, will be processed within 5 days.	FY 02: 97% FY 01: 97% FY 00: 97%	FY 02: 100% (met) FY 01: 97% (met) FY 00: 97% (met) FY 99: 97% FY 98: 99%	B 29-36 P 81
1.9. FOH – Eliminate Barriers to Care—Increase Access Points <i>Clinical Service:</i> Provide needed basic clinical services to Federal employees	FY 02: 225,000 FY 01: 222,300 FY 00: 212,000 FY 99: 210,000	FY 02: 226,000 (met) FY 01: 220,000 (not met) FY 00: 212,276 (met) FY 99: 199,053 (not met) FY 98: 194,609	B 37-45 P 81-82
1.10. Employee Assistance Program: Provide employee assistance services	FY 04: 1.40M FY 03: 1.30 M FY 02: 1.30 M FY 01: 1.18 M	FY 04: FY 03: FY 02: 1.30M (met) FY 01: 1.20 M (met) FY 00: 1.18 M FY 99: 1.17 M FY 98: 1.19 M	B 37-45 P 82-83
1.11. FOH – Environmental Health Services: Increase the hours of environmental health services provided and billed to customers	FY 02: 151,000 FY 01: 133,850	FY 02: 156,591 (met) FY 01: 148,989 (met)	B 37-45 P 83
1.12. Reduce the Unit Core Cost of Personnel/Payroll Services to PSC Customers	FY 02: \$289 FY 01: \$279 FY 00: \$299 per W-2	FY 02: \$288.53 (met) FY 01: \$279 (met) FY 00: \$272 (not met) FY 99: \$284 per W-2, \$299 after effects of inflation	B 18-19 P 83-84

Performance Goals	Targets	Actual Performance	
1.13. Reduce or maintain the unit cost of forms and publications distribution service for HHS customer products	FY 02: Decrease by 5% FY 01: Reduce unit pricing by 10%	FY 02: 10%-40% decrease (met) FY 01: 6% decrease (not met)	B 29-36 P 84
1.14. Maintain unit cost per line (TIP)	FY 02: Maintain \$24.50 FY 01: Maintain \$24.50 FY 00: Maintain \$24.50 FY 99: \$27.20	FY 02: \$24.50 (met) FY 01: \$24.50 (met) FY 00: \$24.50 (met) FY 99: \$24.50 (met) FY 98: \$26.96	B 29-36 P 84
1.15. Refer eligible Health Professions debt to the Office of the Inspector General for exclusion from participation in Medicare	FY 04: 95% FY 03: 95%	FY 04: FY 03: FY 02: 100% (Baseline)	B 23-28 P 85
1.16. Continue centralization of hardware, software and support resources to realize greater gains in managing support activities and taking advantage of economies of scale	FY 04: consolidate at least 3 resources FY 03: consolidate at least 2 resources	FY 04: FY 03: FY 02: consolidated 1 contract and reduced resources by 2 (Baseline)	P 85 5
Strategic Management Objective 2 – Maximize Opportunities to Improve Customer Satisfaction Levels			
2.1. Distribute PSC comment cards and evaluate monthly and conduct a PSC-wide customer satisfaction survey annually	FY 04: Increase to 85% FY 03: Increase to 85% FY 02: Increase of 5% over FY 01 (81.9%)	FY 04: FY 03: FY 02: 72% responded from satisfactory to excellent (not met) (comment cards = 86% very satisfied- FY 02 Baseline) FY 01: 78% responded good or excellent	P 85-86

2.2. Customer Service Training -- Train employees to level of performance that customer satisfaction is achieved the first time	FY 04: 10% improvement measured by customer comment cards and customer satisfaction survey FY 03: 5% improvement measured by customer comment cards and customer satisfaction survey	FY 04: FY 03:	P 86
2.3. Provide customers with on-line invoicing and on-line viewing of bills that provide customers with an accurate, clear, and concise detailing of service provided, with drill-down capability	FY 04: Provide 100% of customers with on-line viewing and billing capability FY 03: Provide 75% of customers with on-line viewing and billing capability	FY 04: FY 03:	P 86
2.4. Assure Quality of Care --Improve Customer/Patient Satisfaction Improve total customer satisfaction among Federal agencies served	FY 03: 95% FY 02: 95% FY 01: 92%	FY 03: FY 02: (3/03) FY 01: 94% (met) FY 00: 89.5% FY 99: No survey done FY 98: 85% FY 97: 78%	B 37-45 P 86-87

Goal-by-Goal Presentation

Strategic Management Objective 1 – Improve PSC Services While Controlling Costs

- 1.1. *Provide management reports that provide relevant and accurate cost, revenue, and Net Operating Result (NOR) information to managers by organization, service, customer, and time period*
Reports will be generated from the new PSC billing system and will replace manually produced reports.
FY 03 Target: Provide accurate management reports covering at least 75% of the PSC services
FY 04 Target: Provide accurate management reports for 100% of the PSC services
- 1.2. *Implement Change Management techniques across PSC to align behaviors with strategy*
The PSC will work with Change Management Specialists in creating a shared direction in line with strategic goals by working with the senior executive team to build a strong team with a common vision. We will do some individual coaching to assist managers in transitioning change to the organization. Concurrently PSC will work with mid-level management in sharing the common vision of the senior executive team and identifying

barriers and solutions to transitioning change. We will also develop critical thinking skills and learn to resolve communication barriers.

FY 03 Target: Work with executive team and mid-level managers to align their perspectives with the strategic goals, vision and values

FY 04 Target: Train 100% of employees in strategic goals, vision, and values

- 1.3. *Develop a Customer Relations Management Program -- Implement one stop shop approach, centralize agreements, sponsor focus groups and customer visits*
Customer Relations Management at the PSC is a customer driven enterprise that provides superior service at a lower cost through centralized customer service channels that are technology enabled. Establish Customer Service Representatives in critical service areas throughout the PSC. Centralize customer service agreements into one area and manage both service levels, pricing and billing from a centralized automated source.
FY 03 Target: 50% implemented
FY 04 Target: 100% implemented

- 1.4. *Achieve at least 5 of 8 of the following acquisition standards.*

Previous GPRA Goal: 2.

This is an accumulation of several PSC standards into one GPRA goal. Achieving a minimum of 5 of the 8 measures provides our acquisition team the impetus to ensure timeliness, but not at the expense of quality.

Baseline: FY 2001 Target 5 of 8 achieved. Goal met. 7 of 8 achieved.

FY 02 Target: 5 of 8 standards achieved. Goal not met. 2 of 7 achieved (1- none processed). This goal was not met because demand exceeded available resources. Staff left and workload increased and processing took longer. Steps are being taken to improve the situation.

- a. Award in 5 working days from receipt of an acceptable RFC 95% of Micro purchases (simplified acquisitions under \$2,500) 70% (Not met)
- b. Award in 15 working days from receipt of an acceptable RFC 95% - simplified acquisitions (less complex under \$100,000) 74% (Not met)
- c. Award in 45 working days from receipt of an acceptable RFC 95% - simplified acquisitions (complex) 93% (Not met)
- d. Award in 90 days from receipt of an acceptable RFC 95% of sealed bid acquisitions - none processed
- e. Award in 90 days from receipt of an acceptable RFC 95% negotiated sole source acquisitions - 87% (Not met)
- f. Award in 135 days from receipt of an acceptable RFC 95% negotiated competitive acquisitions (non-complex) - 100% (Met)
- g. Award in 175 days from receipt of an acceptable RFC 95% negotiated competitive acquisitions (complex) - 86% (Not met)
- h. Expand acquisitions customer base - 1 new customer (Met)

Data Verification and Validation: Data from workload reports.

- 1.5. *Increase use of performance based contracts; Award at least 20% of new eligible PSC service contracts over \$100K as performance based*

Previous GPRA Goal: 37.

Baseline: FY 2001: 33%

FY 02 Target: Increase over FY 01. Goal met. 50%

FY 03 Target: Increase over FY 02

FY 04 Target: Increase over FY 03

Data Verification and Validation: Data from workload reports.

- 1.6. *Achieve at least 4 of 6 performance standards every year*

Previous GPRA Goal: 3.

Baseline: FY 2001 Target 4 of 6 achieved. Goal met. 6 of 6 achieved.

FY 02 Target: 4 of 6 achieved. Goal met. 6 achieved.

- Achieve a 95% Fill Rate standard for the SSC - 96% (Met)
- Achieve a .5% Delivery Discrepancy Rate for the SSC - .16% (Met)
- Achieve a .05% Damaged Shipment Rate for the SSC - .04% (Met)
- Achieve a .4% Shipping Accuracy Rate for the SSC - .12% (Met)
- Achieve a 95% Rate in Meeting the Order Turn-Around Time Standard - 95% (Met)
- Achieve a 95% Customer Satisfaction Rate with SSC Services - 95% (Met)

1.7. *Increase or maintain level of service calls corrected during first response*

Previous GPRA Goal: 11.

FY 01 Target: 94% Goal met. 95% of service calls were corrected on first call.

Service calls are received for the Parklawn Complex for cleaning, pest control, heating and air conditioning, air quality, security, safety, electrical service, and recycling. Each call is noted and the appropriate service provider (lessor, contractor, etc.) is contacted for remedial action. All actions are recorded and a list of calls is printed for each building daily noting which calls are completed and which calls are still outstanding. A follow-up is performed for all incomplete calls. The person receiving these calls must have a knowledge of facility services to effectively communicate with the service providers. We look for trends in service calls which may be a part of a larger mechanical or operational problem. If the larger problem is resolved, the number of calls should decrease.

FY 02 Target: Increase over FY 2001. Goal met. 96%

Data Verification and Validation: All actions are recorded and a list of calls is printed for each building daily, noting which calls are completed and which calls are still outstanding. Those calls that have not been completed will be counted as unsuccessful unless justified (requires replacement or major repair, needs parts, corrective action requires scheduled outage, etc.) A staff member will place random calls to customers to determine whether or not calls are corrected during the first visit. A data base is kept for these call backs which is used to determine the percentage of calls corrected during the first response.

1.8. *Properly addressed incoming and outgoing mail will be processed within one day.*

Shipments received with special agreements, e.g. large mailings, will be processed within 5 days.

Previous GPRA Goal: 12

FY 01: Target: 97% of properly addressed incoming and outgoing mail will be processed within one day. Shipments with special agreements, e.g., large mailings, will be processed within five days. Goal met. 97%

FY 02 Target: 97%. Goal met. 100%

Data Verification and Validation: All incoming mail pieces are received and accounted for by mail room personnel. Single piece mail is separated from bulk mailings. Twice daily the mail supervisor(s) visually checks all sorting bins, tubs, work areas, and delivery carts to ensure that all correctly addressed mail has been sorted, processed, and delivered. Supervisor(s) also maintains records concerning bulk mailings received and ensures that they are completed within 5 workdays of receipt.

1.9. *FOH -- Eliminate Barriers to Care--Increase Access Points--Clinical Service: Provide needed basic clinical services to Federal employees*

Previous GPRA Goal: 13.

FOH provides clinical services to employees and consultation to management under two different types of inter-agency agreements: (1) walk-in service at permanent centers

offering basic, comprehensive, nationally-standardized clinical services; and (2) specialized, on-demand clinical interventions wherever needed to help agency managers meet their specific occupational health responsibilities arising out of legislative and regulatory requirements or agency initiatives.

In the baseline year of 1998, services were provided to approximately 195,000 employees. The FOH goal is to capture an ever-increasing share of the market for occupational health services to Federal workers. There are not the usual resource restraints, since FOH is 100% reimbursable, and contract provider staff can be added as needed.

Out-year targets were based on FOH's FY 99 performance in which 199,000 employees were served in its Health Centers. The actual performance level is stated in terms of the Federal population covered by FOH clinical agreements for the basic, standard package of services that is sold at a per-capita, annual rate of \$91. Projected levels are based on the volume of current business, a historical 95% renewal rate for clinical interagency agreements, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

FOH also offers specialized fee-for-service clinical services and consultations, which equaled (in dollar sales) the basic clinical services in FY 1997, exceeded them by \$2.5M in FY 1998, and now is expected to exceed basic services by a greater percentage each year. Downward revisions of targets for basic clinical service coverage are due to this shift in agency customer's preference toward purchasing specialized services on a fee-for-service basis.

FY 01 Target: 222,300. Goal not met. 220,000

FY 02 Target: 225,000. Goal met. 226,000

1.10. *Employee Assistance Program: Provide employee assistance services*

Previous GPRA Goal: 14.

Employee Assistance Programs provide consultation to supervisors regarding employee services (assessment of employee emotional, substance abuse, or situational problems that may interfere with job performance) and short-term counseling for employees. Employees are more likely to be helped early in the course of an illness when confrontation and resolution occurs in the job setting, and when the source of help is close at hand and easy to access. This reduces the cost of treatment (including Federal benefits costs) and returns the employee to a more productive status sooner, thus minimizing productivity losses. Critical incident stress debriefing benefits groups of otherwise well employees who have just suffered trauma on the job. It helps them understand normal reactions to abnormal situations, and offers individual personal assistance when necessary.

The baseline is the number of employees to whom these services were available from FOH in FY 1998. In FY 98, services were available to 1.19 million Federal employees. Projected levels are based on the volume of current business, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

FY 01 Target: 1.18M Goal met. 1.20M

FY 02 Target: 1.30M Goal met. 1.30M

FY 03 Target: 1.30M

FY 04 Target: 1.40M

1.11. *FOH -- Environmental Health Services: Increase the hours of environmental health services provided and billed to customers*

Previous GPRA Goal: 41.

Environmental health services enable Federal agencies to comply with legislative and regulatory requirements for job safety/health and environmental matters. Methods include environmental and worker exposure monitoring, hazardous waste/materials management, safety audits, and training of employees and managers. These services meet the agency's need to create a safe workplace, and to identify, evaluate and control occupational health and environmental hazards to health. They protect employees, visitors, the general public, and the man-made and natural environment. They aid in the reduction of both work-related and non-work-related injury and illness.

The baseline uses FY 1998 numbers of over 22,000 specific environmental services provided. This includes the number of safety inspections performed, indoor air quality studies done, etc. The data comes out of the FOH Management Information System. Projected levels are based on the volume of current business, marketing efforts, and trends such as agency budget pressures, competitors' successes, and downsizing.

FY 01 Target: 133,850 hours. Goal met. 148,989 hours.

FY 02 Target: 151,000 hours. Goal met. 156,591 hours.

1.12. *Reduce the unit core cost of personnel/payroll services to PSC customers*

Previous GPRA Goal: 33.

Baseline: \$284 per W-2, \$299 after effects of inflation in FY 99. Inflation assumptions used were: Pay and benefits were increased by 3.3% in FY 00 and 3.2% for FY 01; Non-pay items were inflated by 2.1% in FY 00 and 2.2% in FY 01.

FY 00: Target: \$299 per W-2, Goal met. \$272 The reduction in systems operating expenses, streamlining and/or eliminating functions and re-engineering systems processes were begun and caused a decrease in the FY 00 unit core cost. With inflation as a factor, we cannot expect a significant decrease to continue into FY 01 and 02 unless the W-2 base increases. We will be working on improving the present personnel/payroll system as well as developing the new system.

FY 01 Target: \$279. Goal met. \$279 per W-2. (The FY 01 target of \$290 was changed to \$279 to reflect the FY 01 budget numbers.)

FY 02 Target: \$289 (Less than FY 99). Goal met. \$288.53

Data Verification and Validation: Costs are extracted from CORE accounting reports and billing reports produced by the PSC and reviewed by independent accountants during the annual financial statement audit.

The HHS legacy payroll system is in need of modernization. PSC had planned to upgrade the payroll system in FY 03 by moving to PeopleSoft pay in conjunction with the conversion of all HHS personnel records to PeopleSoft HR. This initiative was budgeted for in FY 03 and would have resulted in higher rates for payroll services to account for implementation costs. The costs were expected to decline in the out years once the integrated PeopleSoft HR/Pay system was in place. In the interim, OMB/OPM developed an initiative to reduce the number of Federal payroll providers to 3 by the end of FY 03. HHS submitted a proposal to become one of the Federal payroll providers using a PeopleSoft solution. We were told in September that HHS was not selected as a

provider. We will be seeking payroll services from the Defense Finance and Accounting Service (DFAS).

1.13. *Reduce or maintain the unit cost of forms and publications distribution service for HHS customer products*

Previous GPRA Goal: 34.

Baseline: FY 01 Target: 10% decrease. Goal not met. 6% decrease (average)

FY 02 Target: 5% decrease. Goal met. In general, decreases in costs for HHS customer products ranged from 10% to 40% for the categories of services. Distribution services with other Federal agencies have allowed for the reduction of distribution fees for HHS customers. The pricing information below shows the reductions in pricing for HHS customers. There was one increase; the rate for inventory services was increased by \$.50 in May 2001 to cover increases in personnel costs.

HHS Customer-Owned Material

As of	Each (place, pull, package, deliver)	Package (place, pull, package, deliver)	Full Box (place, pull, package, deliver)	Print on Demand	Assemble Packets/Manuals (each)	Inventory Services (per half hour)
12/01/98	\$1.75	\$6.50	\$9.75	\$0.10	\$6.00/\$47.50	\$12.50
05/01/00	\$1.50	\$5.50	\$8.75	\$0.10	\$5.00/\$42.50	\$10.00
05/01/01	\$1.00	\$3.30	\$5.25	Free Link	\$4.50/\$42.50	\$10.50
10/01/02	\$1.00	\$3.15	\$5.00	Free Link	\$4.25/\$41.50	\$10.50

1.14. *Maintain unit cost per line (TIP)*

Previous GPRA Goal: 35.

Baseline: \$26.96 average for FY 98.

The monthly cost for each line includes all line features (e.g., call forwarding), installations and repairs performed during the regular work day, voice mail, all voice mail features (e.g., faxing and 1-800 access), and a modem pool. The objective of the Telecommunications Improvement Plan (TIP) is to maintain unit line costs consistent with the TIP contract based on volume of calls, number of lines, and milestones identified in the contract.

FY 99 Target: \$27.20. Reduced the unit line cost by 9.1% to \$24.50 by September 30, 1999.

FY 00 Target: Maintain the unit cost per line at \$24.50, Goal met. Unit cost per line \$24.50.

FY 01 Target: Maintain the unit cost per line at \$24.50, Goal met. Unit cost per line \$24.50.

FY 02 Target: Maintain the unit cost per line at \$24.50, Goal met. Unit cost per line \$24.50.

The TIP contract will end sometime around the 3rd quarter of FY 03 to be replaced by a GSA contract already competed and awarded. Costs will no longer be controlled by the PSC. The GSA contract will provide the services that TIP provided; costs for those services will be between GSA and Verizon. HHS is currently negotiating with GSA and Verizon on what the services and cost will be.

Data Verification and Validation: Costs per line are calculated by reviewing actual bills from Verizon for all the lines purchased and averaging those costs over the fiscal year.

1.15. *Refer eligible Health Professions debt to the Office of the Inspector General for exclusion from participation in Medicare*

Prompt, accurate, effective collection and deposit of funds owed to the Government is essential to fulfillment of public financial and program objectives. Timely exclusion from Federally supported Medicare reimbursement for services has been highly effective in achieving compliance from medical professionals who fail to meet legal debt obligations to the Government.

FY 02 Baseline: 100%

FY 03 Target: 95%

FY 04 Target: 95%

1.16. *Continue centralization of hardware, software and support resources to realize greater gains in managing support activities and taking advantage of economies of scale*

FY 02 Baseline: Consolidated 1 contract and reduced resources by 2. When the IRMS was formed in the summer of 2001, all support contracts were transferred to the new Service. In FY 2002, the IRMS reviewed agency support requirements and available resources from the current support contracts. Contracts were reviewed for redundancies and opportunities to eliminate unneeded services. The Silver Spring Center PC Support contract was consolidated with the PSC PC Support contract for a cost savings of \$700 for the first quarter of FY 2002. Also, with the formation of the IRMS it was possible to initiate consolidation of Network Servers to ensure the most efficient use of agency hardware and avoid purchasing unneeded equipment. IRMS started with 7 HP systems and 3COM routers, at a maintenance cost of \$257K. 1 HP was given to the EHRP project, 4 of the seven HP systems life cycle were replaced by 2 HP systems now under warranty. The 3COM routers were replaced by Cisco routers because 3COM went out of the router business. The remaining 2 HP systems and Cisco routers maintenance cost is \$140K which equals a savings of \$117K. Also, IRMS submitted necessary paperwork to transfer the HRS Oracle license to the HHS Enterprise Oracle License Plan for existing licenses and maintenance support. Under the Departmental plan the cost is \$4,506. Renewal under the supermini contract would have cost \$130K. This action will generate a cost savings in excess of \$125K.

FY 03 Target: Consolidate at least 2 resources

FY 04 Target: Consolidate at least 3 resources

Strategic Management Objective 2 – Maximize Opportunities to Improve Customer Satisfaction Levels

2.1. *Distribute PSC comment cards and evaluate monthly and conduct a PSC-wide customer satisfaction survey annually*

This goal was revised to include the PSC comment cards with the survey to measure customer satisfaction. The PSC has developed a customer satisfaction survey instrument to replace many of the individual surveys previously sent out in an effort to provide consistency across the PSC and eliminate "survey saturation" of our customers. Surveys will be sent out on a yearly basis in the late August or September time frame to coincide with the end of the fiscal and performance years. In addition we distribute PSC comment cards with services/products provided and evaluate monthly the feedback on the cards.

Previous GPRA Goal: 1.

Baseline: FY 2001 = 78% responded good or excellent

FY 02 Target: 5% over FY 01 (81.9%). Goal not met. 72% responded satisfactory to excellent in the annual customer satisfaction survey distributed in the first quarter of FY 02. The customer comment cards distributed during the second half of the fiscal year rated 86% very satisfied. FY 02 baseline for the comment cards = 86%

FY 03 Target: Increase to 85%

FY 04 Target: Increase to 85%

Data Verification and Validation: Data from PSC Customer Survey.

- 2.2. *Customer Service Training --Train employees to level of performance that customer satisfaction is achieved the first time*

FY 03: 5% improvement measured by customer comment cards and customer satisfaction survey

FY 04: 10% improvement measured by customer comment cards and customer satisfaction survey

- 2.3. *Provide customers with on-line invoicing and on-line viewing of bills that provide customers with an accurate, clear, and concise detailing of service provided, with drill-down capability*

The new billing system will not have full Intra-governmental payment and collection (IPAC) capability until FY 04. SSC and FOH will not be included initially because they mostly have outside customers. Although the system will have on-line viewing and billing capability, it will still be partially a manual process until we fully integrate all of PSC.

FY 03: Provide 75% of customers with on-line viewing and billing capability

FY 04: Provide 100% of customers with on-line viewing and billing capability

- 2.4. *Assure Quality of Care--Improve Customer/Patient Satisfaction*
Improve total customer satisfaction among Federal agencies served
 Previous GPRA Goal: 15

Customer satisfaction is measured by survey mechanisms. Fiscal year 1997 was the first year FOH systematically collected customer satisfaction data, so that data is the first baseline available. The results of that survey indicated that 78% of FOH's customers were satisfied with the services they purchased for their employees. In 1998, FOH conducted a more comprehensive survey of 1200 of its Federal managers to determine their satisfaction with the services delivered under each of its programs. On average, 85% of FOH's customers rated its services either "Good" or "Excellent." In FY 2000, a similar survey was conducted. The results of that survey indicated that, on average, 90% of FOH's customers rated its services either "Good" or "Excellent." FOH will continue to conduct such customer-wide surveys on an annual basis. In terms of future targets, the program reviews the last survey's numbers and estimates how much improvement can reasonably be accomplished.

Also, in 1998, FOH began to use "how-did-we-do-today?" postcards to get satisfaction ratings from individual employees who used basic clinical services or visited an EAP counselor. The most recent responses showed that 98% of users considered FOH clinical services "excellent" or "good." Repeated EAP user surveys consistently produce excellent or good ratings in the 93-100% range for FOH's counseling services.
 FY 01 Target: 92%. Goal met. In FY 2001, 94% of FOH's customers indicated that they were either very or extremely satisfied with the services provided by FOH.

FY 02 Target: 95%. Available 3/03
FY 03 Target: 95%

II. - Financial Resource Management – Provide PSC, HHS and other agencies with modern, fully integrated financial operations needed to properly account for effective economic use of public funds, and provide full, accurate reporting.

FINANCIAL RESOURCE MANAGEMENT			
Performance Goals	Targets	Actual Performance	Reference
Strategic Management Objective 3 – Improve PSC Financial Performance and Assure Budget and Performance Integration			
3.1. Achieve unqualified (clean) audit opinions for the PSC and its customers	FY 04: 100% FY 03: 100% FY 02: Unqualified	FY 04: FY 03: FY 02: (1/03-3/03) FY 01: 6/6 Unqualified (met) FY 00: 5/6 Unqualified (met) FY 99: 5/6 Unqualified (met)	B 23-28 P 89 
3.2. Reduce PSC and customer material weaknesses (MW) and reportable conditions (RC)	FY 04: No new FY 03: No new FY 02: 0	FY 04: FY 03: FY 02: (1/03-3/03) FY 01: See chart on page 90 FY 00: 51.7% FY 99: 7 MWs	B 23-28 P 90 
3.3. Implement automated costing model to allow proper alignment of fully burdened costs to the proper product/service and integration of product costs to the budget	FY 04: Cost, price, and budget 100% of PSC services using an automated costing model FY 03: Provide 100% of PSC managers an automated costing tool to use to compare to existing costs/rates	FY 04: FY 03:	P 91 
3.4. Review and negotiate 85% of Indirect Cost Rate Proposals within six months of receipt	FY 02: 85%	FY 02: 91% (met) FY 01: 93%	B 23-28 P 91
3.5. Exceed the OMB Objective of 95% of Vendor Invoices Paid on Time	FY 02: Exceed 95% FY 01: Exceed 95% FY 00: Exceed 95% FY 99: Exceed 95%	FY 02: 99.8% (met) FY 01: 99.8% (met) FY 00: 99.7% (met) FY 99: 98.3% (met) FY 97: 96.75%	B 23-28 P 91

3.6. Refer delinquent debts to TOP within required timeframe	FY 02: 95%	FY 02: 100% (met) FY 01: 100% FY 00: 100% FY 99: 100% FY 97: 90%	B 23-28 P 91
3.7. Reduce erroneous payments to recipients of government funds (minimum base of .075% of total payments) Commercial Payments Travel Management System Payment Management System	FY 02: .075%	FY 02: .038% (met) FY 01: .0025%	B 23-28 P 91
3.8. Implement Results Oriented Management -- Create performance contracts for all PSC supervisors and managers that tie their performance to the PSC strategic plan	FY 03: Performance contracts in place within 120 days after the beginning of the rating period.	FY 03:	B 18-19 P 91 1

Goal-by-Goal Presentation

Strategic Management Objective 3 – Improve PSC Financial Performance and Assure Budget and Performance Integration

3.1. *Achieve unqualified (clean) audit opinions for the PSC and its customers:*

Substance Abuse & Mental Health Services Administration (SAMHSA)

Health Resources & Services Administration (HRSA)

Administration for Children and Families (ACF)

Administration on Aging (AoA)

Indian Health Service (IHS)

Previous GPRA Goal: 17-22.

The PSC provides financial services for PSC and five of the HHS agencies. Obtaining an unqualified audit opinion from independent auditors is a significant performance measure of how PSC manages its financial data.

FY 99 Target: Unqualified opinions for the above HHS agencies with the exception of IHS. Met. 5/6 unqualified

FY 00 Target: Unqualified opinions for the above HHS agencies with the exception of IHS. Met. 5/6 unqualified

FY 01 Target: Unqualified opinions for PSC and its customers. Goal met. The PSC and its HHS agency customers all received unqualified financial opinions in the FY 2001 audits of financial statements. (6/6)

FY 02 Target: Unqualified. (1/03-3/03)

FY 03 Target: 100%

FY 04 Target: 100%

Data Verification and Validation: Independent auditors.

3.2. *Reduce PSC and customer material weaknesses (MW) and reportable conditions (RC)*

Previous GPRA Goal: 23-28.

FY 00: Target: 100%, Goal not met. 51.9% of reportable conditions were resolved. Of the 11 reportable conditions pertaining to PSC activities, four were successfully resolved by the completion of the FY 99 audit. PSC staff are utilizing all available resources and holding periodic status meetings with OS, OIG and auditor representatives to appraise actions underway to resolve all reportable conditions.

FY 01: Target: 100%, Goal not met. 54.5% of reportable conditions were resolved by 9/30/01. Only two reportable conditions are expected to be unresolved by the completion of the FY 01 audit.

The PSC provides financial services for PSC and five of the HHS agencies. Previous GPRA Goals discussed resolving reportable conditions; this goal sets in place the proactive goal of having no new findings.

Baseline: FY 2001 payment data.

FY 02 Target: 0. (1/03-3/03)

FY 03 Target: No new

FY 04 Target: No new

Data Verification and Validation: Independent auditors.

Summary of FY 2001 Material Weaknesses

Internal Control Finding	ACF	HRSA	SAMHSA	PSC	AoA	IHS
Fund Balance w Treasury Transactions and Reconciliations	N/A	N/A	N/A	N/A	N/A	X
Preparation and Analysis of Financial Statements	N/A	N/A	N/A	N/A	N/A	X
TOTAL = 2						

Summary of FY 2001 Reportable Conditions

Reportable Conditions	ACF	HRSA	SAMHSA	PSC	AoA	IHS
Grant Accounting	X	X	X	N/A	N/A	N/A
Preparation and Analysis of Financial Statements	X	X	X	X	X	N/A
Electronic Data Processing DFO	X	X	X	X	X	X
Electronic Data Processing OPDIV	X	X	X	N/A	X	X
Accounting for Interagency Grant Funding Agreements	N/A	X	X	N/A	N/A	X
Accounting for Malpractice Litigation Claims	N/A	X	N/A	N/A	N/A	N/A
Fund Balance w Treasury Transactions and Reconciliations	N/A	N/A	N/A	N/A	N/A	N/A
Deferred Revenue	N/A	N/A	N/A	N/A	N/A	X
Accounts Receivable	N/A	N/A	N/A	N/A	N/A	X
Single Audit Act	N/A	N/A	N/A	N/A	N/A	X
TOTAL = 10						

- 3.3. *Implement automated costing model to allow proper alignment of fully burdened costs to the proper product/service and integration of product costs to the budget*
 FY 03 Target: Provide 100% of PSC managers an automated costing tool to use to compare to existing costs/rates
 FY 04 Target: Cost, price, and budget 100% of PSC services using an automated costing model
- 3.4. *Review and negotiate 85% of indirect cost rate within six months of receipt*
 Previous GPRA Goal: 29.
 Baseline: FY 2001: 93%
 FY 02 Target: 85%. Goal met. 91%
- 3.5. *Exceed the OMB objective of 95% of vendor invoices paid on time*
 Previous GPRA Goal: 31.
 Baseline: 96.75% in FY 97
 FY 99: During FY 99, 98.3% of invoices were paid on time.
 FY 00 Target: Exceed 95%. Goal met. 99.7%
 FY 01 Target: Exceed 95%. Goal met. 99.8% (264,007) of vendor invoices were paid on time.
 FY 02 Target: Exceed 95%. Goal met. 99.8%
Data Verification and Validation: Report on Prompt Pay, as required by the Prompt Pay Act.
- 3.6. *Refer delinquent debts to TOP within required timeframe*
 Previous GPRA Goal: 32.
 Baseline: 90% of debts referred in FY 97.
 FY 99: 100% of verified delinquent debt was referred to TOP within 75 days after the end of each quarter.
 FY 00 Target: Refer 100%, Goal met. 100%
 FY 01 Target: Refer 100% within 75 days of end of quarter. Goal met. 100%
 FY 02 Target: 95%. Goal met. 100%
- 3.7. *Reduce erroneous payments to recipients of government funds (minimum base of .075% of total payments)*
 The PSC maintains a financial system which makes disbursements to commercial vendors, a grant management system (PMS) for grant disbursements, and a travel management system (TMS) for HHS travel payments.
 Previous GPRA Goal: 16.
 Baseline: FY 2001: .0025%
 FY 02 Target: .075%. Goal met. .038%
Data Verification and Validation: Data from CORE financial system and TMS.
- 3.8. *Implement results oriented management – Create performance contracts for all PSC supervisors and managers that tie their performance to the PSC strategic plan.*
 FY 03 Target: Performance contracts in place within 120 days after the beginning of the rating period.
Data Verification and Validation: Supervisors verify that contracts are in place.

III. – Business Strategy and Innovation: Continuously provide creative and proactive management and leadership that develops and improves business relationships. Run an efficient competitive sourcing program and encourage more and better use of IT/E-Gov.

BUSINESS STRATEGY AND INNOVATION			
Performance Goals	Targets	Actual Performance	Reference
Strategic Management Objective 4 – Optimize E-Gov Opportunities and Ensure Competitive Sourcing Compliance			
4.1. Partner with other Federal agencies to provide services	FY 04: Review 50% of products for partnering FY 03: Review 25% of products for partnering	FY 04: FY 03:	P 93
4.2. Increase Non-Waivered Electronic Disbursements	FY 02: 85% FY 01: 85% FY 00: 100% FY 99: Increase to 100%	FY 02: 100% (met) FY 01: 95.6% (met) FY 00: 87.6% (not met) FY 99: 81.4% (not met) FY 97: 7.3%	B 23-28 P 94 
4.3. Expand on-line procurements and E-government services; Post all synopses over \$25K on Government-wide web site	FY 02: Increase over FY 01	FY 02: 100% (met) FY 01: 100% posted	B 29-36 P 94 
4.4. Payment Management -- Increase the number of recipient organizations reporting electronically	FY 02: Increase over FY 01 FY 01: 15,000 FY 00: 4,000 FY 99: 3,500	FY 02: 17,157 (met) FY 01: 16,500 (met) FY 00: 11,500 (met) FY 99: 9,486 (met) FY 98: 2,100	B 23-28 P 94 
4.5. Implement Human Resources automation tools	FY 04: 3 HR tools FY 03: 6 HR tools	FY 04: FY 03:	B 18-19 P 94-95  6

Goal	Performance	Performance	Performance
4.6. Replace Present Legacy Human Resources System with a State-of-the-Art HR System	FY 04: Add additional enhancements as determined by the EHRP Steering Committee FY 03: Add two enhancements FY 02: Develop prototype FY 01: Begin design & development of new system	FY 04: FY 03: FY 02: Prototype developed. Deployment completed. (met) FY 01: Development completed; prototype being tested. (met)	B 18-19 P 95 6
4.7. Develop a three-year competitive sourcing plan and complete competitive sourcing studies for commercial activities in the PSC according to OMB goals and based on the PSC FAIR Inventory for FY 00	FY 04: No new target FY 03: 10% of inventory (61-or balance of cumulative goal of 92) FY 02: 5% of inventory (31)	FY 03: FY 02: Plan developed. 12.4% of inventory (75) studied and converted to contract (met) FY 00: 614 on PSC FAIR Inventory	B 29-36 P 95  4

Goal-by-Goal Presentation

Strategic Management Objective 4 – Optimize E-Gov Opportunities and Ensure Competitive Sourcing Compliance

4.1. Partner with other Federal agencies to provide services

This goal is developmental, based upon the results of PSC's review of products for partnering. We have had discussions with USDA and plan to partner with them as our furniture refurbishing source. We are in ongoing discussions with NIH regarding them taking over our GSA leased vehicle management.

FY 03 Target: Review 25% of products for partnering

FY 04 Target: Review 50% of products for partnering

4.2. *Increase non-waivered electronic disbursements with an 85% minimum*

Previous GPRA Goal: 30.

Baseline: 7.3% in FY 97.

FY 99 Target: Increase to 100%. Goal not met. 81.4% (revised from preliminary estimate of 75.9%) of commercial invoices were processed by EFT as of the end of FY 99. Major resistance from utility companies, health providers, universities, and state agencies has slowed progress. Mass mailings are not effective because individual invoices must be returned for vendors to see cause and effect. Some universities and states maintain multiple bank accounts for various types of payments and a single set of account information is often inapplicable to every campus or department within the university or state system. Many utility companies use invoice and account numbers that are longer than 10 positions and report they cannot identify EFT payments when these numbers are truncated. The U.S. Treasury has established problem solving work groups with PSC participation.

FY 00 Target: 100%, Goal not met. 87.6%. To achieve better results, the PSC has entered into an interagency agreement with Treasury to participate in the Payment Advice Internet Delivery (PAID) system whereby vendors can obtain additional information on the EFT payments they receive. The PSC is expanding the number of positions in the invoice and account fields in order to resolve utility company complaints. The targets for FY 01 and 02 have been revised to accommodate the factors outside of our control.

FY 01 Target: 85%. Goal met. 95.6%.

FY 02 Target: 85%. Goal met. 100%

Data Verification and Validation: Data is tracked through the PSC EFT report.

4.3. *Expand on-line procurements and E-government services; Post all synopses over \$25K on government web site*

Previous GPRA Goal: 38.

Baseline: FY 2001: 100% posted on Government-wide web site (<http://www2.EPS.gov>)

FY 02 Target: Increase over FY 01. Goal met. 100%

Data Verification and Validation: Data from PSC PRISM automated acquisition system and web-site data.

4.4. *Payment Management - Increase the Number of Recipient Organizations Reporting Electronically*

Previous GPRA Goal: 39.

FY 01 Target: Increase to 15,000 Goal met. 16,500 recipient accounts use the electronic PSC 272 system. PSC continued its efforts to convert all recipients to the electronic reporting mechanism. In as much as the Department has "clean audits" as one of its top priorities, timely reporting of disbursements is an integral part of that process. Therefore, PSC continues in an aggressive plan to convert most, if not all, of its recipients to electronic reporting.

FY 02 Target: Increase over FY 01. Goal met. 17,157 recipient accounts use the electronic PSC 272 system.

4.5. *Implement Human Resources automation tools.*

We plan to complete implementation of the following automation tools, currently in progress, by the end of FY 03: QuickHire, Avue, on-line exit survey, on-line entry-on-duty forms, on-line survey of new hires, and the automated RPL/CTAP listing for

outplacement. As we implement more automation tools that will improve our service delivery, we should be able to reduce staff costs and/or redirect their efforts to strategic initiatives.

FY 03 Target: Implement 6 HR automation tools.

FY 04 Target: Implement 3 additional HR tools

Data Verification and Validation: Automated tools in place and being used by HHS human resources staffs to improve service delivery.

4.6. *Replace present legacy HR system with a state-of-the-art HR system*

Previous GPRA Goal: 40.

FY 01 Target: Begin design and development of new system; System will be developed with contractor support, EHRP Government Design and Development Team. Goal met. Prototype tested and certified for deployment. Completed system and operational testing and began deployment of core system.

FY 02 Target: Develop prototype. Goal met. Prototype developed. All OPDIVs were deployed during FY 02.

FY 03: Add two enhancements

FY 04: Add additional enhancements as determined by the EHRP Steering Committee

Data Verification and Validation: EHRP status reports to HHS agencies and systems enhancements in place.

4.7. *Develop a three-year competitive sourcing plan and complete competitive sourcing studies for commercial activities in the PSC according to OMB goals and based on the PSC FAIR Inventory for FY 00*

Previous GPRA Goal: 36.

FY 00 Baseline: 614 on PSC FAIR Inventory

FY 02 Target: 5% of inventory (31). Goal met. A comprehensive PSC Competitive Sourcing Plan was developed and approved. 12.4% of inventory (75) studied. 60 regional administrative support FTEs were converted to contract under a competitive selection process. The remaining 15 FTEs, which were comprised of seven different activities, were directly converted under existing contracts.

FY 03 Target: 10% of inventory (61)

No FY 04 Target. The next target is in FY 05 - 50% of inventory. PSC will work toward the FY 05 target during FY 04.

Data Verification and Validation: FY 2000 PSC FAIR Inventory Report.

IV. – Employee Management and Development: Develop and implement human capital systems that foster equal opportunity and promote recruitment and retention in PSC's major skills areas and position types. Promote training and retraining of PSC employees.

EMPLOYEE MANAGEMENT AND DEVELOPMENT			
Performance Goals	Targets	Actual Performance	Reference
Strategic Management Objective 5 – Managing Human Capital Strategically			
5.1. Implement workforce strategies and systems to recruit and retain	FY 04: Develop a recruitment plan FY 03: Complete workforce analysis	FY 04: FY 03:	B 18-19 P 97-98 2
5.2. Achieve overall increase in employee satisfaction PSC-wide	FY 02: Increase of 5% over FY 01 (71.1%)	FY 02: 60% (not met) FY 01: 67.7%	P 98
5.3. Cross-train/re-train PSC staff to accommodate those impacted by outsourcing, consolidation or restructuring	FY 04: 100% of those impacted FY 03: 100% of those impacted	FY 04: FY 03:	B 18-19 P 98 2
5.4. Exceed the OPM Timeliness Requirement of 80% of Payroll Separation Processing Actions to OPM within 30 days	FY 02: Exceed 80% FY 01: 85% FY 00: 85% FY 99: 80%	FY 02: 86% (met) FY 01: 84% (not met) FY 00: 82% (not met) FY 99: 87% (met) FY 98: 83%	B 18-19 P 98
5.5. Position Classification Services: Develop 95% of position descriptions, evaluation statements and supporting documents within 2-10 work days (routine actions)	FY 02: 95%	FY 02: 94% (not met) FY01: 95%	B 18-19 P 98-99
5.6. Personnel Staffing Services: Prepare 90% of vacancy announcements within 2-3 working days upon receipt of the classified Position Description	FY 02: 90%	FY 02: 95% (met) FY 01: 93%	B 18-19 P 99

5.7. Executive recruitment: 90% of vacancy announcements will be done 2-10 workdays upon receipt of classified PD	FY 02: 90%	FY 02: 100% (met) FY 01: 95%	B 18-19 P 99
5.8. Personnel processing services: 90% of pay documents will be processed within the pay period (unless last Friday)	FY 02: 90%	FY 02: 99% (met) FY 01: 92%	B 18-19 P 99
5.9. 95% of all Commissioned Corps online applicants to be personally contacted, oriented, and educated within 3 working days on the Corps and given access to entire application.	FY 02: 95%	FY 02: 96% (met) FY 01: 90%	B 20-22 P 99
5.10. 95% of all Commissioned Corps applicants will be issued orders within 5 working days after hiring agency issues a form PHS-1662	FY 02: 95%	FY 02: 100% (met) FY 01: 95%	B 20-22 P 99-100
5.11. Delayer and streamline PSC; decrease supervisor to employee ratio	FY 02: Increase over FY 01	FY 02: 1:9 supervisor to employee ratio (met) FY 01: 1:8.4 supervisor to employee ratio	P 100 2
5.12. Reduce incidents of workplace violence, thefts, and threats to Federal property	FY 02: Decrease over FY 01 FY 01: Maintain number of incidents FY 00: Maintain number of incidents FY 99: Reduce number of incidents	FY 02: 11 (met) FY 01: 13 (met) FY 00: 14 FY 99: 8 FY 98: 17	B 29-36 P 100

Goal-by-Goal Presentation

Strategic Management Objective 5 – Managing Human Capital Strategically

- 5.1. *Implement Workforce Strategies and Systems to Recruit and Retain*
The PSC will conduct a workforce analysis that documents our attrition rate(s) by series/grade/location; projects attrition for the next 5 years; and provides a gap analysis of what types of skills will be needed. We will also develop a plan to recruit, retain and train to meet the gaps.

FY 03 Target: Complete workforce analysis

FY 04 Target: Develop a recruitment plan

Data Verification and Validation: Workforce analysis process in place; Recruitment plan in place.

5.2. *Achieve overall increase in employee satisfaction*

Previous GPRA Goal: 43.

The PSC has developed an employee satisfaction survey instrument to baseline specific issues as they relate to the workforce. This is a tool to assist the PSC in one of its Strategic Goals of "Employee Management and Development." Surveys will be sent out on a yearly basis in the late August or September timeframe to coincide with the end of the Fiscal and Performance Year.

Baseline: FY 2001: 67.7% rated good to excellent.

FY 02 Target: Increase of 5% over FY 01 (71.1%). Goal not met. For FY 02, PSC measured employee satisfaction through the DHHS Human Resource Management Index survey which summarizes employee descriptions of their work environment. 60% of the PSC employees who responded answered "neutral to very positive" on the question "How do the people in your work group feel about their OPDIV/STAFFDIV"?

Data Verification and Validation: Data from the PSC results of the Human Resource Management Index survey.

5.3. *Cross-train/re-train PSC staff to accommodate those impacted by outsourcing, consolidation or restructuring*

FY 02: With the PSC's consolidation of activities and workforce restructuring efforts we have had the opportunity to either cross-train or re-train employees. For example, when all IT personnel were transferred into IRMS, it was possible to cross train personnel to provide additional back-up for current systems and develop support for new initiatives.

FY 03 Target: Cross-train/re-train 100% of those impacted

FY 04 Target: Cross-train/re-train 100% of those impacted

Data Verification and Validation: Staff deployed to valid positions.

5.4. *Exceed the OPM timeliness requirement of 80% of separation actions to OPM within 30 days*

Previous GPRA Goal: 4.

FY 01 Target: 85%. Goal not met. 84%. We continue to work closely with agency personnel staff and provide personnel officers/HR directors with statistics of their staffs' performance, stressing the importance of submitting timely actions.

FY 02 Target: Exceed 80 %. Goal met. 86% of payroll separation processing actions to OPM within 30 days.

Data Verification and Validation: In addition to the OPM report, the Personnel and Pay Systems Division has a separation tracking system which they use to ensure they are processing separation actions timely.

5.5. *Position Classification Services: Develop 95% of position descriptions, evaluation statements and supporting documents within 2-10 work days (routine actions)*

Previous GPRA Goal: 5.

This goal replaced a general HR goal of all personnel actions to one with a more specific and customer-focused objective. By developing a 95% standard, we are able to account for anomalies, yet provide customers with a 95% accountable measure.

Baseline: FY 2001 Target: 95%. Goal met 95%

FY 02 Target: 95%. Goal not met. 94%. A substantial increase in the customer base effected the results of this goal.

Data Verification and Validation: Data from PSC HR logs.

- 5.6. *Personnel Staffing Services: Prepare 90% of vacancy announcements within 2-3 working days upon receipt of the classified Position Description*
Previous GPRA Goal: 6.

This goal replaced a general HR goal of all personnel actions to one with a more specific and customer-focused objective. By developing a 90% standard, we are able to account for anomalies, yet provide customers with a 90% accountable measure.

Baseline: FY 2001 Target 90% Goal met. 93%.

FY 02 Target: 90%. Goal met 90%

Data Verification and Validation: Data from PSC HR logs.

- 5.7. *Executive recruitment: 90% of vacancy announcements will be done 2-10 workdays upon receipt of classified PD*
Previous GPRA Goal: 7.

This goal replaced a general HR goal of all personnel actions to one with a more specific and customer-focused objective. By developing a 90% standard, we are able to account for anomalies, yet provide customers with a 90% accountable measure.

Baseline: FY 2001 Target 90% Goal met. 95%.

FY 02 Target: 90%. Goal met 95%

Data Verification and Validation: Data from PSC HR logs.

- 5.8. *Personnel processing services: 90% of pay documents will be processed within the pay period (unless the last Friday)*
Previous GPRA Goal: 8.

This goal replaced a general HR goal of all personnel actions to one with a more specific and customer-focused objective. By developing a 90% standard, we are able to account for anomalies, yet provide customers with a 90% accountable measure.

Baseline: FY 2001 Target 90% Goal met. 92%.

FY 02 Target: 90%. Goal met 99%

Data Verification and Validation: Data from PSC HR logs.

- 5.9. *95% of all Commissioned Corps online applicants to be personally contacted, oriented, and educated within 3 working days on the Corps and given access to entire application*
Previous GPRA Goal: 9

One of the specific missions of the PSC Division of Commissioned Corps Personnel has been the timely and responsive recruitment of new applicants. This goal provides a measurable objective from which the Commissioned Corps can be measured with respect to new applicants.

Baseline: FY 2001 Target 95% Goal not met. 90%

FY 02 Target: 95%. Goal met. 96%

Data Verification and Validation: Data from Commissioned Corps web-based tracking system and logs.

- 5.10. *95% of all Commissioned Corps applicants will be issued orders within 5 working days after hiring agency issues a form PHS-1662*

Previous GPRA Goal: 10.

One of the specific missions of the PSC Division of Commissioned Corps Personnel has been the timely and responsive recruitment of new applicants. This goal provides a measurable objective from which the Commissioned Corps can be measured with respect to those officers who have been offered a commission.

Baseline: FY 2001 Target 95% Goal met. 95%

FY 02 Target: 95%. Goal met. 100%

Data Verification and Validation: Data from Commissioned Corps web-based tracking system and logs.

5.11. *Delay and streamline PSC; decrease supervisor to employee ratio*

Previous GPRA Goal: 42.

Baseline: FY 2001: 1:8.4 supervisor to employee ratio

FY 02 Target: Increase over FY 01. Goal met. 1:9 supervisor to employee ratio in FY 02

Data Verification and Validation: FY 2001 PSC supervisor to employee ratios as indicated in the HHS payroll database.

5.12. *Reduce incidents of workplace violence, thefts and threats to Federal property*

Previous GPRA Goal: 44.

These are incidents requiring follow-up; i.e., violent threats or actions requiring reports to law enforcement personnel or review by the workplace violence committee; thefts that get reported to the Federal Protection Service for investigative purposes; and threats that require partial or full evacuation of the building or that are of such serious a nature that they alter the way we conduct our normal business.

FY 01 Target: Maintain reduced incidents of workplace violence, thefts and threats to Federal property on an annual basis at or below the FY 2000 level. Goal met. 13

FY 02 Target: Decrease under FY 01. Goal met. 11

Data Verification and Validation: A database of incident reports is maintained throughout the fiscal year and reviewed for inclusion in the final total at year's end.

Part III

APPENDIX TO THE PERFORMANCE PLAN

III.**APPENDIX TO THE PSC PERFORMANCE PLAN****A.1 Linkage to HHS and Agency Strategic Plans**

Services offered by the PSC contribute to enhanced capacity for the HHS program components to meet their challenges for the future. Successful achievement of PSC's performance goals will save HHS agency funds for administrative support. Therefore, we consider that our Plan supports all of the HHS strategic goals from an administrative support perspective.

As a fee-for-service organization, we must continuously review our processes with sensitivity toward the long-range goals of retaining our current customers and acquiring new ones. The PSC realizes that workloads and priorities from our customers vary based on the influences and pressures inherent in their own organizations, across the Federal Government and, in some instances, even globally. Our strategic planning anticipates the need for constant improvement in the accuracy of information, while continuously trying to find alternative methods which will result in reduced fees and maximized performance for customers. This proactive approach in developing strategic objectives recognizes that information and feedback from our customers, our vendors, and our employees serve as an invaluable and essential role in shaping our future customer service and marketing efforts. We further realize that only by conducting extensive analysis of new acquisition methods, technical developments, and market trends can we maintain and expand our current competitive edge, and accelerate our growth in the Federal marketplace.

A.2 Changes/Improvements Over Previous Year

In an effort to focus on PSC-wide and outcome oriented goals we have streamlined the PSC FY 03 and FY 04 Performance Plans. Many of the FY 02 goals and targets, which are largely service area outputs, have been dropped from these Plans. Although many of the FY 02 goals will no longer be reported in GPRA, we will continue to track those, and many others, through our performance management plans. We have gone from 44 goals in FY 02 to 21 in FY 03 and 19 in FY 04.

A. The Following FY 02 Goals are being dropped from FY 03 and FY 04 Plans in an effort to focus on outcome goals in the PSC Performance Plan. The following goals are output goals for specific service areas. We will continue to track these goals through our performance plans.

1.4. Achieve at least 5 of 8 of the following acquisition standards each year:

- a. Award in 5 working days from receipt of an acceptable RFC 95% of Micro purchases (Simplified Acquisitions under \$2,500)
- b. Award in 15 working days from receipt of an acceptable RFC 95% of simplified acquisitions (less complex under \$100,000)
- c. Award in 45 working days from receipt of an acceptable RFC 95% of simplified acquisitions (complex)
- d. Award in 90 days from receipt of an acceptable RFC 95% of sealed bid acquisitions
- e. Award in 90 days from receipt of an acceptable RFC 95% negotiated sole source acquisitions
- f. Award in 135 days from receipt of an acceptable RFC 95% negotiated competitive acquisitions (non-complex)
- g. Award in 175 days from receipt of an acceptable RFC 95% negotiated competitive acquisitions (complex)
- h. Expand acquisitions customer base

1.6. Achieve performance standards every year at Supply Service Center:

- a. Achieve a 95% Fill Rate standard for the SSC
- b. Achieve a .5% Delivery Discrepancy Rate for the SSC
- c. Achieve a .05% Damaged Shipment Rate for the SSC
- d. Achieve a .4% Shipping Accuracy Rate for the SSC
- e. Achieve a 95% Rate in Meeting the Order Turn-Around Time Standard
- f. Achieve a 95% Customer Satisfaction Rate with SSC Services

1.7. Increase or maintain level of Building Management service calls corrected during first response

1.8. Properly addressed incoming and outgoing mail will be processed within one day. Shipments received with special agreements, e.g., large mailings, will be processed within 5 days.

Continued – A. The Following FY 02 Goals are being dropped from FY 03 and FY 04 Plans in an effort to focus on outcome goals in the PSC Performance Plan. The following goals are output goals for specific service areas. We will continue to track these goals through our performance plans.

1.9. FOH – Eliminate Barriers to Care—Increase Access Points

Clinical Service: Provide needed basic clinical services to Federal employees

1.11. FOH -- Environmental Health Services: Increase the hours of environmental health services provided and billed to customers

1.12. Reduce the Unit Core Cost of Personnel/Payroll Services to PSC Customers

1.13. Reduce or maintain the unit cost of forms and publications distribution service for HHS customer products

1.14. Maintain unit cost per line (TIP)

3.4. Review and negotiate 85% of Indirect Cost Rate Proposals within six months of receipt

3.5. Exceed the OMB Objective of 95% of Vendor Invoices Paid on Time

3.6. Refer delinquent debts to TOP within required timeframe

3.7. Reduce erroneous payments to recipients of government funds (minimum base of .075% of total payments)

Commercial Payments
Travel Management System

4.2. Increase Non-Waivered Electronic Disbursements

4.3. Expand on-line procurements and E-government services; Post all synopses over \$25K on Government-wide web site

4.4. Payment Management --Increase the number of recipient organizations reporting electronically

5.2. Achieve overall increase in employee satisfaction PSC-wide

5.4. Exceed the OPM Timeliness Requirement of 80% of Payroll Separation Processing Actions to OPM within 30 days

5.5. Position Classification Services: Develop 95% of position descriptions, evaluation statements and supporting documents within 2-10 work days (routine actions)

Continued - A. The Following FY 02 Goals are being dropped from FY 03 and FY 04 Plans in an effort to focus on outcome goals in the PSC Performance Plan. The following goals are output goals for specific service areas. We will continue to track these goals through our performance plans.
5.6. Personnel Staffing Services: Prepare 90% of vacancy announcements within 2-3 working days upon receipt of the classified Position Description
5.7. Executive recruitment: 90% of vacancy announcements will be done 2-10 workdays upon receipt of classified PD
5.8. Personnel processing services: 90% of pay documents will be processed within the pay period (unless last Friday)
5.9. 95% of all Commissioned Corps on-line applicants to be personally contacted, oriented, and educated within 3 working days on the Corps and given access to entire application.
5.10. 95% of all Commissioned Corps applicants will be issued orders within 5 working days after hiring agency issues a form PHS-1662
5.11. Delayer and streamline PSC; decrease supervisor to employee ratio
5.12. Reduce incidents of workplace violence, thefts, and threats to Federal property
B. The following goals were included in the FY 2002 Plan but have been revised in the FY 2003 and FY 2004 Plans:
2.1. Distribute PSC comment cards and evaluate monthly and conduct a PSC-wide customer satisfaction survey annually. This goal was revised to include the PSC comment cards as a mechanism to measure customer satisfaction.
3.1. Achieve unqualified (clean) audit opinions for the PSC and its customers. This goal was listed separately by OPDIV in the FY 2002 Plan. In the FY 2003 and FY 2004 Plans it is combined into one PSC-wide goal
3.2. Reduce PSC and customer material weaknesses (MW) and reportable conditions (RC). This goal was listed separately by OPDIV in the FY 2002 Plan. In the FY 2003 and FY 2004 Plans it is combined into one PSC-wide goal
4.7. Develop a three-year competitive sourcing plan and complete competitive sourcing studies for commercial activities in the PSC according to OMB goals and based on the PSC FAIR Inventory for FY 00. This goal was revised to include the competitive sourcing plan. (This goal has targets for FY 03 and FY 05 – no target for FY 04)
C. The following goals are for FY 2003-only:
2.4. Assure Quality of Care --Improve Customer/Patient Satisfaction -- Improve total customer satisfaction among Federal agencies served. This goal will be incorporated into PSC-wide goal 2.1. after FY 03.
3.8. Implement Results Oriented Management -- Create performance contracts for all PSC supervisors and managers that tie their performance to the PSC strategic plan. New goal for FY 03 only.

D. The following are new goals for FY 2003 and FY 2004
1.1. Provide management reports that provide relevant and accurate cost, revenue, and Net Operating Result (NOR) information to managers by organization, service, customer, and time period
1.2. Implement Change Management techniques across PSC to align behaviors with strategy
1.3. Develop a Customer Relations Management Program -- Implement one stop shop approach, centralize agreements, sponsor focus groups and customer visits
1.15. Refer eligible Health Professions debt to the Office of the Inspector General for exclusion from participation in Medicare
1.16. Continue centralization of hardware, software and support resources to realize greater gains in managing support activities and taking advantage of economies of scale
2.2. Customer Service Training -- Train employees to level of performance that customer satisfaction is achieved the first time
2.3. Provide customers with on-line invoicing and on-line viewing of bills that provide customers with an accurate, clear, and concise detailing of service provided, with drill-down capability
3.3. Implement automated costing model to allow proper alignment of fully burdened costs to the proper product/service and integration of product costs to the budget
4.1. Partner with other Federal agencies to provide services
4.5. Implement Human Resources automation tools
5.1. Implement workforce strategies and systems to recruit and retain
5.3. Cross-train/re-train PSC staff to accommodate those impacted by outsourcing, consolidation or restructuring

A.3 Partnerships and Coordination

The PSC's success as an organization depends upon its innovative public-private sector partnerships. The PSC adheres to a policy of partnership with both its customers and vendors. Employees work cooperatively to find solutions to problems should they occur and to lay the proper groundwork to prevent disputes and disagreements among the contract parties.

The PSC's market for its support services include all agencies and Departments of the Federal Government and the District of Columbia. The range of services and products that the PSC has developed and cultivated in concert with its customers has enabled management to begin to expand its core customer network. This strategy has enabled PSC to optimize the opportunities that management believes exist within Government agencies while investing in its own workforce and infrastructure.

Currently, the PSC provides services and products to the following representative sample of Executive Branch agencies:

- Department of Agriculture
- Department of Commerce
- Department of Defense

- Department of Education
- Department of Energy
- Department of Health and Human Services
- Department of Housing and Urban Development
- Department of the Interior
- Department of Justice
- Department of Labor
- Department of State
- Department of Transportation
- Department of the Treasury
- Department of Veterans Affairs

Representative independent establishments and Government corporations currently receiving products and services include the following:

- Architect of the Capitol
- Consumer Product Safety Commission
- D.C. Government
- Environmental Protection Agency
- Federal Deposit Insurance Corporation
- Federal Emergency Management Agency
- General Accounting Office
- Internal Revenue Service
- National Aeronautics and Space Administration
- National Archives and Records Administration
- Office of Personnel Management
- Peace Corps
- Railroad Retirement Board
- Securities and Exchange Commission
- Small Business Administration
- Social Security Administration
- U.S. Agency for International Development
- U.S. Courts
- U.S. Postal Service

The expanding list of customers reflects the commitments that the PSC has made to its customers and the capabilities of its workforce to address the needs of diverse customers. Whether responding to embassies world-wide, ships-at-sea, national emergencies or processing payroll and grants and contracts payments, the PSC maintains high standards for performance.

PSC staff meet with customers on a routine basis to determine concerns, additional services needed, enhancements needed to current systems or processes, and reporting needs. Employees participate in Government-wide forums to keep abreast of new policies and procedures, new concepts and technologies, and take advantage of training opportunities offered to keep current in their areas of responsibility.

We communicate on an ongoing basis with members of the SSF Board of Directors to discuss current and future administrative service needs and options within HHS.

A.4 Data Verification and Validation

Current operating reports such as budget reports, personnel action status reports, and the personnel/payroll data file, are utilized to develop baseline and actual operating data and are augmented with customer/user groups and employee and customer satisfaction surveys. Repeat surveys are used to gauge the effect of any corrective actions and to identify further

improvement targets. Formal reports, audits and other data sources are used to periodically verify and validate the actual performance data.

A.5 Performance Measurement Linkages to Cost Accounting, Information Technology Planning, Capital Planning and Program Evaluation

Cost Accounting

The account structure for the PSC is established in sufficient detail to enable the CORE accounting system to accumulate cost and revenue data at the cost center/product line level. Availability of this data allows for the preparation of monthly or quarterly financial statements for management review. Summary data that is directly tied to the budgets is prepared for presentation to the Board of Directors.

Information Technology (IT) Planning

Information Technology oversight is provided by the PSC Chief Information Officer (CIO). Our portfolio of IT investments is monitored by the PSC Information Technology Investment Review Board (ITIRB), which includes the CIO and senior PSC management. The PSC ITIRB was chartered to ensure that our funds are expended only for information systems investments that take into consideration risk adjusted returns and emphasizes interoperability, improved delivery of services, and reduced costs where possible. Whenever a new investment is proposed to the PSC ITIRB, its sponsoring business area must gain the approval of the ITIRB using a business case that follows the OMB and HHS guidance. The functions described in the business case must be mission critical; there must be assurance that no other government or private entity can do the function more cost effectively; business processes must have been simplified or otherwise redesigned to reduce cost and improve effectiveness. Additionally, PSC's IT decision-making process is structured to comply with the requirements of the HHS ITIRB as well as the SSF Board of Directors.

During FY 2001 the PSC began to reorganize its IT resources into a new Service, the Information Resources Management Service (IRMS). The purpose of the new Service is to leverage PSC IT resources, effect cost savings and efficiencies, minimize the number of FTEs required, and address dynamic regulatory and administrative environments. During FY 2002, the PSC IRMS reorganization completion is being revisited in order to ensure compliance with "One Department" initiatives such as the small OPDIV consolidation. The PSC has played an active role within the small OPDIV consolidation consortium by participating in group meetings establishing mission and goals, participating in development of a Statement of Work (SOW) for contractor support for the consortium, meeting with the contractor during the initial data gathering phase after contract award, and hosting meetings for the consortium. In this manner, PSC is fostering the tenants of the "One Department" methodology.

PSC has also participated in Departmental workgroups aimed at consolidating individual OPDIV IT initiatives and tearing down stovepipes within the groups. As part of that effort aimed at "One Department," PSC has active and/or leading members for the Departmental Enterprise Architecture, 45 Day IT Asset Inventory, Enterprise Directory, Network Modernization, HHS

Web Portal, Public Key Infrastructure (PKI), Section 508 Compliance, UFMS, and Security Groups.

Capital Planning

PSC takes capital planning seriously as an internal initiative as well as supplying input to Departmental objectives. The PSC has provided significant input to the HHS IT Strategic Plan, authoring the sections of the Plan regarding the Enterprise Human Resources and Payroll Plan (EHRP) and E- Payroll. Additionally, as part of Departmental program team efforts, PSC has provided input in the following areas: Departmental Enterprise Architecture, Enterprise Directory, Network Modernization, HHS Web Portal, PKI, Section 508 Compliance, UFMS, HHS IT Consolidation, and Security. This participation contributed to a more complete Plan. This information is in addition to specific documentation on the PSC internal capital planning projects. PSC capital planning projects include: (1) EHRP - an approach to defining the future direction of the human resources and payroll systems support for HHS. To ensure successful implementation of the EHRP, the PSC has involved HHS agencies in identifying requirements and evaluating alternatives that best meet the Department's needs. PSC continued to involve the OPDIVs in assisting them through the implementation process through training and on-site expertise where needed; (2) the Commissioned Officer Payroll and Personnel System (COPPS) - replaces the Commissioned Corps Personnel and Payroll System and completed an ITIRB during FY 2002. Discussions are ongoing for this to be a possible outsource initiative to the Coast Guard; and, (3) the Telecommunications Improvement Project (TIP) - a contract which provides mission critical telephone services to HHS customers.

Program Evaluation

The PSC's evaluation priorities are to evaluate the effectiveness of PSC activities and identify weaknesses in services provided with a view towards improving those services. Our financial performance is formally reviewed annually. Throughout the PSC, financial performance data in terms of costs versus revenues are reviewed to ensure efficient and effective performance in the service-for-fee arena. In the Spring of each year, a formal mid-year review is conducted and presented to the Board of Directors. This process evaluates the performance of each activity in terms of costs versus revenues for the year to determine the need for any mid-year rate adjustments, identify potential rebates or other issues needing further discussion. Customer feedback is analyzed to foster a service-oriented environment that delivers time sensitive, qualitative goods and services.

Management evaluates all this information in the context of improving business practices and organizational effectiveness within the realm of decreased costs, increased efficiencies or increased productivity. Management also uses this information to shift resources where appropriate to develop or improve overall business while maintaining an organizational competitive edge.

WEDNESDAY, APRIL 9, 2003.

BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES

WITNESSES

**JERRY HAUER, ACTING ASSISTANT SECRETARY FOR PUBLIC HEALTH
EMERGENCY PREPAREDNESS, DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

**JULIE GERBERDING, DIRECTOR, CENTERS FOR DISEASE CONTROL
AND PREVENTION**

**BETTY DUKE, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES
ADMINISTRATION**

ELIAS ZERHOUNI, DIRECTOR, NATIONAL INSTITUTES OF HEALTH

**ANTHONY FAUCI, DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND
INFECTIOUS DISEASES**

Mr. REGULA. We will get the hearing started. We have a very important topic this morning on homeland security. I think this is something that 280,000,000 Americans are concerned, and they think about it, and they are actually relying on our government agencies to be alert to the concerns that they have and they give them a sense of security. So I guess like in your own hometown, you are glad the fire department is there and the police department, it gives you a sense of security. And our goal is through our agencies to do the same thing for all of America. So we are happy to welcome all of you here this morning.

And as I understand it, Mr. Hauer, you will speak for the group.

Mr. HAUER. That is correct.

Mr. REGULA. Would you introduce your panel? Maybe you would like to wait until Dr. Gerberding gets here.

Mr. HAUER. She is in the building. She will be up in a moment or two.

Mr. REGULA. Let's get started. Members get busy. They have other commitments. Your full statement will be made a part of the record. You can summarize as you choose. Then we will have questions.

Mr. HAUER. Thank you, Mr. Chairman. It is a pleasure to be with you here today. I am Jerry Hauer, the Acting Assistant Secretary for Public Health Emergency Preparedness. I appreciate this opportunity to provide an overview of the Department of Health and Human Services fiscal year 2004 request for bioterrorism and public health emergency preparedness funding and to apprise you of our efforts over the past year in working with State and local governments to address bioterrorism and other public health emergencies.

Accompanying me today are Dr. Julie Gerberding, who should be here momentarily, the Director of the Centers for Disease Control; Dr. Betty Duke, the Administrator of the Health Resources and

Services Administration; Dr. Elias Zerhouni, the Director of the National Institutes of Health; and Dr. Anthony Fauci, the Director of the National Institute of Allergy and Infectious Diseases. As you know, that is a component of NIH.

The Department of Health and Human Services has continued to work vigorously to ensure the Nation's readiness to respond to bioterrorism and other public health emergencies. We are doing this by pursuing a multipronged approach that consists of enhancing public health and hospital preparedness at State and local levels, vaccinating smallpox and healthcare response teams as well as other health workers and first responders, and conducting research and development on countermeasures for biological and chemical agents most likely to be used as weapons of mass destruction.

In my remarks today I will provide a brief status, an overview, on the progress HHS has made over the past year in preparing the Nation to address bioterrorism and other public health emergencies and preview our plans and initiatives for fiscal year 2004.

STATE AND LOCAL PUBLIC HEALTH PREPAREDNESS

A little over a year ago Congress enacted supplemental appropriations that provide HHS with more than a billion dollars to enhance public health preparedness and to upgrade the readiness of hospitals and other health care entities to address bioterrorism and other public health emergencies. Within weeks of the appropriation, HHS awarded \$1,100,000,000 in cooperative agreements to 50 States, 3 municipalities and the American territories. Twenty percent of this money was released immediately to defray costs for activities related to the events of September 11th, 2001, and to provide States with sufficient resources to prepare comprehensive work plans for submission to the Department.

Following receipt and review of the State work plans within a record-breaking 30 days, HHS released the remaining 80 percent of the funds by July 1st of 2002. In adopting this approach, HHS struck a careful, considered balance among speed, flexibility, and accountability. The cooperative agreement funding has made a material difference at the State and local levels. For 90 percent of the States, of the 50 States and 3 municipalities, New York City, Los Angeles, and Chicago, that have been awarded—that have been awarded funds have developed systems for 24-hour, 7-day-a-week notification or activation of their public health emergency response plans, and 87 percent of the grantees have developed interim plans to manage and distribute pharmaceuticals, equipment and supplies from the strategic national stockpile. In 95 percent of the jurisdictions systems are being developed to receive and evaluate urgent disease reports on a 24/7 basis. Ninety-one percent indicated that they could initiate a field investigation within 6 hours of an urgent disease report.

This year CDC and HRSA will award approximately \$1,400,000,000 to the States, three municipalities, the American Territories and the Freely Associated States of the Pacific to further expand their effort in State and local preparedness. CDC will be awarding cooperative agreements totalling \$870,000,000, and HRSA will award \$498,000,000 for enhancing the preparedness of hospitals and other healthcare facilities.

In addition, HRSA will provide \$28,000,000 to academic health centers and other public health professional training entities for a new initiative: Bioterrorism preparedness education and training for clinical providers.

In view of the war in Iraq and heightened terrorist threats at home, we are taking steps to ensure that States and other awarding jurisdictions have the resources they may require immediately to strengthen and upgrade their readiness. Recently Secretary Thompson announced that HHS is prepared to release upon request from the States an advance of up to 20 percent of the jurisdiction's fiscal year 2003 funding allocation to be used for the following purposes: Support for their smallpox vaccination activities for healthcare workers and emergency responders; support activities already approved in the 2002 State plans which need additional resources now; to enhance or intensify critical activities already approved under last year's State work plans; or accelerate time lines for these critical activities. This option is strictly voluntary. Funding will be awarded in full to all of the States at the end of this summer following the review and the approval of their fiscal year 2003 work plans.

Over the course of the last several months, as State and local health departments have begun to develop their preparedness plan, a number of issues have been brought to our attention. One is the extent of Federal support of local health departments and their activities. We have heard from both State and local health departments each expressing legitimate concerns about what should be their appropriated allocation. In creating our public health preparedness cooperative agreement program, we elected to adopt a State-centric model in which the State serves as a unit of government responsible for coordinating, integrating and overseeing preparedness efforts. We look to the Governors to provide the executive leadership to ensure that statewide activities are carried out responsibly and successfully.

Having said that, though, the Department does recognize the bona fide needs of local health departments. Given that fiscal year 2002 was the first year of substantial funding, a significant share of the funds was used by some States to develop infrastructure, hire staff, award contracts and develop relationships with other emergency planning organizations. This year, however, we expect the larger portion of the funds will reach local communities. Our guidance will contain explicit language to support local public health and local hospital preparedness.

Workforce shortages are another challenge for States seeking to improve their public health and hospital preparedness. States have frequently mentioned that their problems in recruiting and retaining staff are not only because of noncompetitive salary structures, but also because of the limited pool of qualified individuals. With the education and training funds provided by the ongoing CDC and HRSA cooperative agreements, and by HRSA's new initiative in continuing education and curriculum development for bioterrorism, HHS intends to address a number of these problems.

HHS is also collaborating on a project with the Association of the Schools of Public Health that is intended to establish, implement and evaluate curriculum and training programs for public health

workers. This effort will identify our public health workforce, our public health workforce needs and provide a road map for building the capacities necessary to ensure preparedness at State and local levels. We do recognize, however, that producing an adequate cadre of professionals in specific disciplines, for example, epidemiologists and laboratorians, is a long-term challenge.

The GAO will soon be releasing a report on State and local report preparedness, and I believe that report was released last night, and many of you should have copies. It is a fair and informative assessment that provides a useful overview of readiness activities that have taken place in the States and cities that were part of the study. The report made two recommendations: One, that benchmarks be developed to define adequate preparedness for use by State and local jurisdictions to assess and guide their preparedness efforts; and two, an information-sharing mechanism to be established whereby HHS can evaluate solutions to common problems utilized by one or more jurisdictions and, if appropriate, share those strategies with other jurisdictions.

In their fiscal year 2002 guidances, CDC and HRSA provided benchmarks to guide the States in developing capabilities in readiness assessment, surveillance and epidemiology, hospital preparedness, biological laboratory capacity, information technology, risk communication and public information, and education and training. This year's guidance will expand on previous benchmarks and will include new ones to further assist in their planning activities and gauging their level of preparedness.

Later this year HHS will undertake a project to develop a repository of best practices for the States. We will identify best practices in a variety of areas that could include, but not be limited to, a readiness assessment, disease reporting systems, assessment of food and water vulnerabilities, development of surge capacity for handling mass casualties, risk communication, and preparedness training of various types of health professionals. The objective is to identify the different approaches, processes, systems or models that have been successfully developed and implemented by various States and municipalities, validate these best practices, and then share them with public health and hospital preparedness communities throughout the country.

The President's fiscal year 2004 budget requests \$940,000,000 for public health preparedness cooperative agreements, 518,000,000 for the hospital preparedness cooperative agreements, and \$60,000,000 for HRSA's biopreparedness training program in recognition of the fact that rebuilding and strengthening of our public health infrastructure and the upgrading of the readiness of hospitals and other health care entities is a multiyear effort.

RESEARCH AND DEVELOPMENT ACTIVITIES

While our State and local partners work to improve their preparedness and response capabilities, the Department is implementing an aggressive research and development program to develop and acquire biological, chemical, nuclear and radiological countermeasures. These initiatives have involved close coordination among NIH, CDC, FDA and DOD and the Office of the Assistant Secretary for Public Health Emergency Preparedness. Research

programs at NIH involving a broad array of scientific initiatives provide new approaches for developing countermeasures to threat agents most likely to be used as terrorist weapons. NIH is supporting basic research in innate and immune responses, microbiology, disease pathogenesis, genome sequencing, proteomics related to the organisms and toxins that could be used by bioterrorist agents, or as bioterrorist agents, and both NIH and CDC support not only early product development efforts, but also advanced development that is carried out in collaboration with industry partners. The FDA works very closely with these partners to provide advice and guidance during the development process, with a view toward facilitating their subsequent submission for regulatory review.

I am pleased to report that the cell culture-based smallpox vaccine is entering the final stages of development. Sixty-seven million doses of ACAM2000 vaccine are now in The Strategic National Stockpile, with the rest to be developed in coming months. Phase 2 clinical trials are now in progress, and the final phase 3 study will begin in August. This program has been implemented with unprecedented speed, beginning with the award of the development contracts in November of 2001, a very, very short time ago, and concluding with licensure expected in 2004. In addition, Vaccinia Immune Globulin, or VIG, has been produced in sufficient quantities to meet the current ongoing needs of the smallpox immunization program. It is anticipated that the entire stockpile requirement will be met by the end of this year.

Initial research and development contracts have been awarded for next-generation anthrax and smallpox vaccines. NIH has awarded contracts to two companies, VaxGen and Avecia, to develop recombinant protective antigen, otherwise known as rPA, vaccines against anthrax. Acambis and Bavarian Nordic are developing under separate NIH contracts safer smallpox vaccines. These efforts are on a very compressed timetable, and reviews of their progress are discussed on a regular basis by an interagency team consisting of NIH, CDC and FDA.

The Department is also engaged in an accelerated program to develop the Nation's defenses against the toxins that cause botulism. HHS is managing a multifaceted program to produce additional supplies of botulinum antitoxins. Our research and development efforts will also include development of a next-generation vaccine against botulinum neurotoxin.

PROJECT BIOSHIELD

The most exciting news in the R&D arena is, of course, Project BioShield. Announced by the President on February 3, 2003, BioShield is a comprehensive and ambitious effort to develop and make available modern effective drugs and vaccines to protect against attacks by biological and chemical weapons. BioShield seeks to ensure that adequate, stable funding will be made available to develop and procure next-generation countermeasures; that NIH has the authority to speed up research and development of promising countermeasures; and that FDA be given the authorization that would permit and facilitate the emergency use of prevent-

ative and therapeutic countermeasures that have not yet completed the formal process for full FDA licensure.

These are truly challenging times for our Department. I believe that we can—we are and have been up to the task, and we look forward to working closely with Congress to ensure that the Nation is better prepared to respond to public health emergencies in general, and bioterrorism in particular.

Mr. Chairman, I thank you for your time and for the opportunity to speak before you today. My colleagues and I would be happy to take any questions that you or members of the committee may have.

Mr. REGULA. Thank you for an excellent statement.

[The information follows:]

STATEMENT

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES

LABOR/ HHS/ ED APPROPRIATIONS SUBCOMMITTEE

JEROME M. HAUER

ACTING ASSISTANT SECRETARY

FOR PUBLIC HEALTH EMERGENCY PREPAREDNESS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

April 9, 2003

Thank you, Mr. Chairman and members of the Committee. I am Jerome M. Hauer, Acting Assistant Secretary for Public Health Emergency Preparedness. I appreciate this opportunity to provide an overview of the Department of Health and Human Services (HHS) FY 2004 request for bioterrorism and public health emergency preparedness funding, and to apprise you of our efforts over the past year in working with state and local governments to address bioterrorism and other public health emergencies. Accompanying me today are Dr. Julie Gerberding, Director of the Centers for Disease Control and Prevention (CDC), Dr. Betty Duke, Administrator of the Health Resources and Services Administration (HRSA), Dr. Elias Zerhouni, Director of the National Institutes of Health and Dr. Anthony Fauci, the Director the National Institute of Allergy and Infectious Diseases, a component of NIH.

The Department of Health and Human Services has continued to work vigorously to ensure the Nation's readiness to respond to bioterrorism and other public health emergencies. We are doing this by pursuing a multi-pronged approach that consists of enhancing public health and hospital preparedness at state and local levels, vaccinating smallpox and healthcare response teams as well as other health workers and first responders, and conducting research and development on countermeasures for the biological and chemical agents most likely to be used as weapons of mass destruction.

In my remarks today I will provide a brief status report on the progress HHS has made over the past year in preparing the nation to address bioterrorism and other public health emergencies, and preview our plans and initiatives for FY 2004.

A little over a year ago Congress enacted supplemental appropriations that provided HHS with more than \$1 billion to enhance public health preparedness and to upgrade the readiness of hospitals and other healthcare entities to address bioterrorism and other public health emergencies. Within weeks of the appropriations, HHS awarded \$1.1 billion in

cooperative agreements to 50 states, 3 municipalities, and the American territories. Twenty percent of this money was released immediately to defray costs for activities related to the events of September 11, 2001 and to provide states with sufficient resources to prepare comprehensive workplans for submission to the Department. Following receipt and review of the state workplans within a record-breaking 30 days, HHS released the remaining 80% of the funds by July of 2002. In adopting this approach, HHS struck a carefully considered balance among speed, flexibility and accountability.

The cooperative agreement funding has made a material difference at the state and local levels. Over 90% of the 50 states and three municipalities (New York City, Chicago and Los Angeles County) that have been awarded funds have developed systems for 24/7 notification or activation of their public health emergency response plans, and 87% of these grantees have developed interim plans to manage and distribute pharmaceuticals, equipment and supplies from the Strategic National Stockpile. In 95% of the jurisdictions, systems are being developed to receive and evaluate urgent disease reports on a 24/7 basis. Ninety-one percent indicated that they could initiate a field investigation within six hours of an urgent disease report.

This year CDC and HRSA will award approximately \$1.4 billion to the 50 states, three municipalities, the American territories and the Freely Associated States of the Pacific (Marshall Islands, Micronesia and Palau) to further expand their efforts in state and local preparedness. CDC will be awarding cooperative agreements totaling \$870 million and HRSA will award \$498 million for enhancing the preparedness of hospitals and other health care entities. In addition, HRSA will provide \$28 million to academic health centers and other health professions training entities for a new initiative -- bioterrorism preparedness education and training for clinical providers.

In view of the war in Iraq and heightened terrorist threats at home, we are taking steps to ensure that states and other awardee jurisdictions have the resources they may require immediately to strengthen and upgrade their readiness. Secretary Thompson announced on March 20th that HHS is prepared to release, upon request from the states, an advance of up to 20% of the jurisdiction's FY 2003 funding allocation to be used for the following purposes: support their smallpox vaccination activities for health workers and emergency responders; support activities already approved in 2002 state plans which need additional resources now; enhance or intensify critical activities already approved under last year's state workplans; or accelerate timelines for these critical activities. This option is strictly voluntary. Funding will be awarded in full to all of the states at the end of the summer, following the review and approval of their FY 2003 workplans.

Over the course of the last several months, as state and local health departments have begun to develop their preparedness plans, a number of issues have been brought to our attention. One is the extent of federal support of local public health department activities. We have heard from both state and local health departments, each expressing legitimate concerns about what should be the appropriate allocation. In creating our public health preparedness cooperative agreement program, we elected to adopt a state-centric model in which the state serves as the unit of government responsible for coordinating, integrating and overseeing preparedness efforts. We look to the governors to provide the executive leadership to ensure that state-wide activities are carried out responsibly and successfully. Having said that, the Department does recognize the bona fide needs of local health departments. Given that FY 2002 was the first year of substantial funding, a significant share of the funds was used by some states to develop infrastructure, hire staff, award contracts and develop relationships with other emergency planning organizations. This year, we expect a larger portion of the funds to

reach the local communities. Our guidance will contain explicit language to support local public health and hospital preparedness activities.

Workforce shortages are another challenging area for states seeking to improve their public health and hospital preparedness. States have frequently mentioned their problems in recruiting and retaining staff not only because of non-competitive salary structures but also because of the limited pool of qualified individuals. With the education and training funds provided by the ongoing CDC and HRSA cooperative agreements and by HRSA's new initiative in continuing education and curriculum development for bioterrorism preparedness, HHS intends to address a number of these problems. HHS is also collaborating on a project with the Association of the Schools of Public Health that is intended to establish, implement, and evaluate curricula and training programs for public health workers. This effort will help identify our public health workforce needs and provide a roadmap for building the capacities necessary to ensure preparedness at the state and local levels. We do recognize, however, that producing an adequate cadre of professionals in specific disciplines (e.g., epidemiologists, laboratorians) is a long-term challenge.

The Government Accounting Office will soon be releasing a report on state and local preparedness. It is a fair and informative assessment that provides a useful overview of readiness activities that have taken place in the states and cities that were part of the study. The report made two recommendations: (1) specific benchmarks be developed to define adequate preparedness for use by state and local jurisdictions to assess and guide their preparedness efforts; and (2) an information-sharing mechanism be established whereby HHS can evaluate solutions to common problems utilized by one or more jurisdictions, and if appropriate, share those strategies with other jurisdictions.

In their FY 2002 guidances, CDC and HRSA provided benchmarks to guide the states in developing capabilities in readiness assessment, surveillance and epidemiology, hospital preparedness, biological laboratory capacity, information technology, risk communication/public information, and education and training. This year's guidance will expand on previous benchmarks and include new ones to further assist states in planning their activities and gauging their level of preparedness.

Later this year, HHS will undertake a project to develop a repository of "best practices" for the states. We will identify best practices in a variety of areas that could include but not be limited to readiness assessment, disease reporting systems, assessment of food and water vulnerabilities, development of surge capacity for handling mass casualties, risk communication, and preparedness training of various types of health professionals. The objective is to identify the different approaches, processes, systems or models that have been successfully developed and implemented by various states and municipalities, validate these "best practices" and then share them with the public health and hospital preparedness communities.

The President's FY2004 budget requests \$940 million for the public health preparedness cooperative agreements, \$518 million for the hospital preparedness cooperative agreements and \$60 million for HRSA's bioterrorism preparedness training program in recognition of the fact that the rebuilding and strengthening of our public health infrastructure and the upgrading of the readiness of hospitals and other health care entities is a multi-year effort.

While our state and local partners work to improve their preparedness and response capabilities, the Department is implementing an aggressive research and development program to develop and acquire biological, chemical, nuclear and radiological countermeasures. These

initiatives have involved close coordination among NIH, CDC, FDA, DoD, and the Office of the Assistant Secretary for Public Health Emergency Preparedness. Research programs at NIH, involving a broad array of scientific initiatives, provide new approaches for developing countermeasures to threat agents most likely to be used as terrorist weapons. NIH is supporting basic research in innate and immune responses, microbiology, disease pathogenesis, genome sequencing and proteomics related to the organisms/toxins that could be used as bioterrorist agents. Both NIH and CDC support not only early product development efforts but also advanced development that is carried out in collaboration with industry partners. The FDA works very closely with these partners to provide advice and guidance during the development process with a view towards facilitating their subsequent submissions for regulatory review.

I am pleased to report that the cell culture based smallpox vaccine is entering the final stages of development. Sixty-seven million doses of ACAM2000 vaccine are now in the Strategic National Stockpile with the rest to be delivered in the coming months. Phase II clinical trials are in progress and the final Phase III study will begin in August. This program has been implemented with unprecedented speed, beginning with the award of the development contracts in November 2001 and concluding with licensure expected in 2004. In addition, Vaccinia Immune Globulin (VIG) has been produced in sufficient quantities to meet the current, ongoing needs of the smallpox immunization program. It is anticipated that the entire VIG stockpile requirement will be met this year.

Initial research and development contracts have been awarded for next-generation anthrax and smallpox vaccines. NIH has awarded contracts to two companies, VaxGen and Avecia, to develop recombinant protective antigen (rPA) vaccines against anthrax. Acambis and Bavarian Nordic are developing, under separate NIH contracts, safer smallpox vaccines.

These efforts are on a very compressed timetable and reviews of their progress are discussed on a regular basis by an interagency team consisting of NIH, CDC and FDA.

The Department is also engaged in an accelerated program to develop the Nation's defenses against the toxins that cause botulism. HHS is managing a multi-faceted program to procure additional supplies of botulinum antitoxins. Our research and development efforts will also include development of a next-generation vaccine against botulinum neurotoxins.

The most exciting news in the R&D arena is, of course, Project BioShield, announced by the President on February 3, 2003. BioShield is a comprehensive and ambitious effort to develop and make available modern, effective drugs and vaccines to protect against attacks by biological and chemical weapons. BioShield seeks to ensure that adequate, stable funding will be made available to develop and procure next-generation medical countermeasures; that NIH has the authority to speed up the research and development of promising countermeasures; and that FDA be given authorization that would permit and facilitate the emergency use of preventive and therapeutic countermeasures that have not yet completed the formal process for full FDA licensure.

These are truly challenging times for our Department. I believe that we are up to the task and we look forward to working closely with Congress to ensure that the Nation is prepared to respond to public health emergencies in general and bioterrorism in particular. Mr. Chairman, thank you for the opportunity to appear before the committee. My colleagues and I will be glad to take any questions that you and other members of the Committee may have.



JEROME M. HAUER

Acting Assistant Secretary for the Office of Public Health Emergency Preparedness
U.S. Department of Health and Human Services

HHS Secretary Tommy G. Thompson named Jerome M. Hauer as Acting Assistant Secretary for the Office of Public Health Emergency Preparedness on June 28, 2002. In this role, Hauer is responsible for coordinating the country's medical and public health preparedness and response to emergencies, including acts of biological, chemical, and nuclear terrorism. The office also oversees bioterrorism preparedness grant funding for state and local governments. Before his appointment as Acting Assistant Secretary in June, Hauer had served as Director of the Office of Public Health Preparedness since May.

Prior to his appointment, Hauer served as senior advisor to the Secretary for National Security and Emergency Management during the events of September 11, 2001, and the nation's anthrax crisis.

Before coming to HHS, Hauer was the first director of the Mayor's Office of Emergency Management (OEM) for New York City. During his tenure at OEM, Hauer was charged with coordinating the city's on-scene response to multi-agency emergencies. He was also responsible for drafting the city's emergency response plans to natural and man-made events, including hurricanes and coastal flooding as well as acts of biological or chemical terrorism.

Hauer served as the executive director of the State of Indiana's Emergency Management Agency, as well as its Department of Fire and Building Services. He also served as co-chairman of the State of Indiana's Emergency Response Commission and as chairman of the board of directors of the State's Public Safety Training Institute. He was on the Congressional Fire Caucus' *Urban Search and Rescue Advisory Committee* as well as the *National Institute for Urban Search and Rescue Advisory Council*. In 1990 and 1991, he was named chairman of the board of directors of the U.S. Earthquake Consortium.

In 1987, Hauer was named Deputy Director for Emergency Management for the City of New York's Emergency Medical Services. Four years earlier, Hauer joined the Biomedical Division of IBM as clinical research coordinator, later taking responsibility for the company's Hazardous Material Response Programs, Crisis Management, Fire

Safety and Emergency Medical Response. A series of hazardous materials training videos produced by Hauer earned him the International Film and TV Critics of New York Bronze Award in 1986.

Hauer has served on the National Academy of Sciences Institute of Medicine's *Committee to Evaluate R&D Needs for Improved Civilian Medical Response to Chemical or Biological Terrorism Incidents*, and was an advisor to the U.S. Capitol Police and the U. S. Marine Corps' Chemical-Biological Incident Response Force. He is an advisor to the Columbia University's School of Public Health and the University of Southern California's School of Medicine. He is also a member of the Johns Hopkins Working Group on Civilian Biodefense.

Hauer has also served as a volunteer firefighter in Ridgefield, Conn., and was a member of the Fairfield County Hazardous Materials Response Team. He was a captain in the U.S. Army Reserve attached to the Walter Reed Army Institute of Research in Washington, D.C.

Hauer has a master's degree from the Johns Hopkins Bloomberg School of Public Health and more than 20 years of experience in emergency management. He was selected as one of six scientists to brief President Clinton on biological terrorism and assisted in the World Health Organization's rewrite of its 1970 monograph on chemical and biological weapons.

While at Hopkins, Hauer developed the first technique for re-infusing blood lost by patients following cardiac surgery. Upon graduation from Johns Hopkins, he spent a short time at the Maryland Shock Trauma Unit and then joined the Beth Israel Hospital in Boston as Research Associate. His research focused on autotransfusion and coagulopathies in trauma and cardiac surgery. Additionally, Hauer served on the faculty of the Northeastern University Paramedic Program and was a teaching assistant in the physiology labs for first- and fourth-year students at Harvard Medical School. He co-directed the first two postgraduate courses in Trauma Management at the Longwood Area Trauma Center of the Harvard Medical School.

Hauer is the recipient of numerous honors, including the Outstanding Alumni of the Year from the Johns Hopkins Bloomberg School of Public Health, the Indiana Commendation Medal for Exceptional Meritorious Service, Legion of Hoosier Heroes Award and the Distinguished Alumni Award from NYU. He is a member of the New York City Police Department's Honor Legion, and is an honorary Assistant Chief in the New York City Fire Department.

Hauer has contributed to 45 publications, a book and two monographs.

TESTIMONY OF
JULIE LOUISE GERBERDING, MD, MPH
DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION
ADMINISTRATOR, AGENCY FOR TOXIC SUBSTANCES AND DISEASE
REGISTRY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, &
EDUCATION

U.S. HOUSE OF REPRESENTATIVES

APRIL 9, 2003

Good afternoon, Mr. Chairman and members of the Committee. I am Dr. Julie Gerberding, Director of the Centers for Disease Control and Prevention (CDC) and Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR). Thank you for the opportunity to testify today about the fiscal year 2004 budget relating to terrorism preparedness and emergency response at CDC. The United States is experiencing threats to its national security that require preparedness for bioterrorism and other public health emergencies. Helping lead this effort is the Centers for Disease Control and Prevention. CDC is committed to helping prevent, prepare for, and respond to acts of terrorism and other public health emergencies. As the current response to Severe Acute Respiratory Syndrome (SARS) shows, we must prepare to respond to all types of public health emergencies. The resources CDC has received in recent years greatly contribute to building preparedness and response capacities across the nation. In FY 2004, CDC will continue to build the capacity of the public health system to prepare for and respond to public health threats. The President's FY 2004 Budget requests \$1.1 billion for CDC's terrorism-related activities.

Current Activities

CDC has set a strategic course to ready our nation for any potential public health threat including terrorism. CDC's preparedness vision statement, "People Protected – Public Health Prepared," and the mission statement, "Prevent death, disability, disease and injury associated with urgent health threats by improving preparedness of the public health system and the public through excellence in science and services," are wide reaching concepts that convey our sense of purpose and commitment. CDC's preparedness strategies include: timely, effective and integrated detection and

investigation; sustained prevention and consequence management programs; coordinated public health emergency preparedness and response; qualified, equipped and integrated laboratories; competent and sustainable workforce; protected workers and workplaces; innovative, relevant and applied research and evaluation; and timely, accurate and coordinated communications. These strategic imperatives target our agency's core competencies to prepare the public health system for all types of emergencies.

Upgrading State and Local Capacity

Bioterrorism, other outbreaks of infectious diseases, and other public health emergencies have significant public health implications that may quickly threaten the health of thousands of people and overwhelm local and state capacities to respond. In FY 2003, CDC is providing \$ 0.9 billion to continue to upgrade state and local capacity to prepare for bioterrorism and other public health emergencies. This funding supports critical public health capacities that are vitally important to national security, such as: preparedness planning and readiness assessment; surveillance and epidemiology capacity; biological and chemical laboratory capacity; communications systems and information technology; health information dissemination and risk communication; and education and training.

CDC conducted numerous activities with resources provided in FY 2002 and continues to do so in FY 2003. Within 90 days of the FY 2002 appropriation, CDC provided all of the appropriated \$918 million to states and selected cities. Because of this quick action, states were able to fund urgent needs and recoup costs incurred in responding to the terrorist attacks of 2001. We are making up to 20% of the FY 2003 funds available on an expedited basis to the states and other eligible entities now, should

they opt to seek it, for smallpox activities and other ongoing initiatives that could benefit from enhanced funding.. In FY 2002, CDC created a terrorism program evaluation process to assess the success of federal, state and local terrorism programs; provided training for more than 1.5 million health professionals in terrorism preparedness and response; and, trained approximately 8,800 clinical laboratorians in terrorism preparedness and response. CDC also provided reference materials to approximately 4,600 clinical laboratories following September 11, 2001. CDC is helping public health laboratories in all 50 states identify bioterrorist threat agents and efficiently communicate laboratory findings. In addition, CDC is providing 110 public health laboratories with the capacity to detect and respond to critical agents and is increasing national response capacity to include food veterinary, environmental and chemical laboratories in the Laboratory Response Network.

With support from CDC, states conducted mock exercises to prepare for terrorism events involving numerous state, county and local agencies; undertook initiatives to develop near real-time syndromic surveillance systems; trained large numbers of staff from public health agencies, health care facilities, emergency management organizations, police and fire departments and other key institutions; created and tested communication systems linking local public health staff and first responders with senior staff from state public health departments, emergency management agencies and other critical state agencies; and enhanced critical capacity at their public health laboratories.

For example, the State of Florida:

- Developed a system to handle mass fatalities – the Florida Emergency Mortuary Operations Response System. Florida will create a Disaster Mass Fatality Plan that should be able to handle over 500 fatalities.
- Implemented its own Epidemic Intelligence Service (EIS) whereby it hired and trained epidemiologists, and matched them with a county or counties to assist in epidemiologic investigations and surveillance activities.
- Held a food contamination tabletop exercise in July 2002. Additional regional exercises are being planned.
- Developed a laboratory manual describing roles, responsibilities, techniques, security, and procedures.
- Provided 100% coverage to the state with the Health Alert Network.

Upgrading CDC Capacity

Emergency Preparedness and Response

CDC has strengthened its internal Emergency Preparedness and Response infrastructure in order to provide enhanced technical and programmatic assistance to states. Some examples include: improved rapid identification and characterization of potential biologic agents; expanded the Epidemic Intelligence Service to assure that well-trained, first-line responders are available to respond to public health emergencies; and developed a secure infrastructure to provide enhanced Geographic Information System (GIS) capability at the federal, state and local levels.

Emergency Communication System

CDC moved quickly to assure that its Emergency Communication System can comprehensively, efficiently, and rapidly respond to communication needs associated with terrorism. This system, currently used to respond to SARS and adverse events related to smallpox vaccinations, can: develop critical information; arrange for immediate direct communication with key collaborators and stakeholders around the world; provide real-time updates to the media; make sure essential information is available to the public through the CDC Web site; maintain a public health response hotline; develop training for clinicians; and develop public service announcements. A central component of this system is the state-of-the art Marcus Emergency Operations Center. This facility is a unique example of a public/private partnership, and was completed in only six months. It is currently the nerve center for CDC's efforts to respond to SARS.

Chemical Terrorism Preparedness and Response

In the event of a major chemical terrorism attack, CDC's chemical laboratory capacity faces many challenges. CDC has improved capacity to rapidly screen for a total of 150 chemicals in blood or urine to be able to better respond to a chemical terrorism incident. In addition, five state environmental health laboratories were funded in FY 2002 to provide surge capacity to the chemical laboratories at CDC. These state laboratories measure chemical agents or their metabolites in human specimens, and in the days following an incident involving human exposure to such chemicals, help CDC accurately determine the chemical agent used in a terrorist attack. In FY 2003 we will continue our initiative begun in FY 2002 to ensure all state public health labs can manage and submit human specimens for chemical analysis. Further, three states have begun a project known as ChemPac to pre-deploy chemical antidotes to local emergency response

agencies. One of the most significant gaps in preparedness across the nation is the paucity of local capability to identify chemical agents or their metabolites in human blood or urine samples during or immediately following an exposure incident – e.g., in time to help emergency responders understand the nature of the incident they face and to help emergency physicians in their diagnosis and treatment decisions. To the extent that such capabilities exist, they typically are associated with hazardous materials response teams or poison control centers. During the coming year, CDC will encourage state and local public health officials to work with their counterparts in public safety agencies to begin remedying this deficiency and will work with other research agencies to enhance the science and technology base relevant to rapid, easily deployed analytical methodologies for potential chemical terrorism agents..

CDC has taken a number of other important steps to ensure readiness in the event of a terrorist attack involving chemicals. Our EOC includes staff from ATSDR with expertise in chemical and medical toxicology, GIS, epidemiology, emergency response and other areas that would be important in responding to a chemical terrorism event. CDC and ATSDR are collaborating in other endeavors related to chemical terrorism, such as preparing toxicological information on industrial chemicals and chemical warfare agents for dissemination to a range of audiences including the general public, emergency responders, health care providers and laboratories. CDC/ATSDR is working to identify the next level of priority toxic substances to address and to fill gaps in research concerning those substances.

CDC's Select Agent Program: Ensuring the Safety and Security of Laboratory Facilities

Through the Select Agent program, CDC is responsible for registering and inspecting laboratories that transfer microorganisms and toxins that pose a significant health risk to humans. This program has inspected more than 100 laboratories across the United States, and is continuing to inspect new labs with a goal of 200 total laboratories inspected by the end of FY 2003. In addition, labs regulated under the select agent program must have a level of security that ensures the proper safekeeping of their biological toxins in order to be allowed to possess or transfer these potentially dangerous substances

Guidelines for Worker Safety in Terrorist Events Issued

CDC has issued new guidelines for protecting emergency responders and for safeguarding building ventilation systems from attack, addressing two of the most pressing terrorism-related worker safety issues. These guidelines give employers and emergency systems practical steps towards increasing safety. CDC is also conducting research to investigate available respirator technology that focuses specifically on technology for emergency responders and counter-terrorism response.

Strategic National Stockpile

CDC continues to be responsible for managing the Strategic National Stockpile (SNS, now owned by the Department of Homeland Security). The mission of SNS is to ensure the availability of life-saving pharmaceuticals, antidotes and other medical supplies and equipment necessary to counter the effects of nerve agents, biological pathogens and chemical agents. The SNS Program stands ready for immediate deployment to any U.S. location in the event of a terrorist attack using a biological, toxin or chemical agent directed against a civilian population. It is comprised of pharmaceuticals, vaccines, medical supplies, and medical equipment that exist to

augment state and local resources for responding to terrorist attacks and other emergencies. These packages are stored in strategic locations around the U.S. to ensure rapid delivery anywhere in the country. Recently, the SNS has prepared specific guidance, and provided technical, planning assistance to states as well as providing funding to them to help them effectively manage the deployment of the SNS at the state level. CDC will now be working closely with DHS on stockpile issues

Smallpox Vaccination Program

In FY 2002, CDC moved swiftly to assure the availability of smallpox vaccine for every person in the United States. In addition, CDC quickly moved to implement the President's smallpox response plan to make sure the United States is prepared to respond to a potential smallpox release. In the event of a smallpox attack, advance vaccination of Smallpox Response Teams will allow them to immediately administer the vaccine to others and care for victims. Progress has been achieved and states may use terrorism response funds to implement the President's plan. Continued focus is needed now for post-smallpox attack preparedness by: preparing and protecting the frontline workforce; detecting, identifying and confirming smallpox disease; and protecting the population through disease investigation.

The implementation of the pre-attack vaccination program will continue to focus on training and education, distributing vaccine to states, and preventing, diagnosing, treating, and monitoring adverse events. To date, over 270,000 vaccine doses have been released to States, and over 29,000 front line workers have been vaccinated. CDC has implemented an adverse reactions monitoring system that has responded to potential

adverse reactions to the vaccine. CDC supports the administration's efforts to provide compensation to people who suffer adverse reactions as the result of taking the vaccine.

Anthrax Vaccine Research

CDC conducts evaluation and research on the currently licensed anthrax vaccine. The purpose of this program is to conduct studies to determine factors associated with side effects from the vaccine. The studies are also expected to provide more information on the point at which the vaccine becomes effective, and how long the protection lasts. The goal is to discover whether the vaccine route can be changed and the number of doses can be reduced, while still providing protection against the disease. By doing this research, CDC hopes to reduce the number of side effects associated with the vaccine, seen particularly in women, while maintaining its effectiveness and increasing its acceptability.

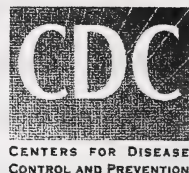
FY 2004 Budget Request

In FY 2004, the President has requested \$1.1 billion, which will provide expanded technical assistance and training to state and local jurisdictions as they move to take on biological, chemical, and radiological mass trauma threats. In addition, CDC will work with states to develop regional preparedness plans to avoid duplication and to coordinate plans for improved preparedness overall. CDC will build its own capacity for preventing biological, chemical and radiological terrorism and coordinate closely with federal partners to improve national preparedness for all hazards. CDC will also pursue a research agenda to further national preparedness response to mass casualty events. The activities funded under Upgrading CDC Capacity include many of CDC's most recognizable programs. From the Epidemic Intelligence Service to the Emergency

Operations Center, CDC will continue to make sure it is ready and able to meet any biological, chemical, or radiological threat.

Generally, CDC will use funds in FY 2004 to: strengthen the public health infrastructure with respect to preparedness for public health emergencies in general, and biological and chemical terrorism in particular; promote regional preparedness planning and dissemination of best practices; expand terrorism preparedness for all biological threat agents; and assess effects of these investments on the public health preparedness and capacities.

CDC has refocused its priorities to be sure the nation is prepared for all types of public health emergencies including biological, chemical, radiological, and conventional terrorist threats. CDC will continue to implement the successful strategies begun in previous years, while remaining flexible in its capability to respond to known and emerging threats. As we continue these efforts, I want to thank the Committee again for its support and for enabling us to do this essential work.



Dr. Julie Louise Gerberding, M.D., M.P.H.

Director, Centers for Disease Control and Prevention
Administrator, Agency for Toxic Substances and Disease Registry
Department of Health and Human Services

Dr. Julie Louise Gerberding, M.D., M.P.H., became the Director of the Centers for Disease Control and Prevention (CDC) and the Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR) on July 3, 2002.

Before becoming CDC Director and ATSDR Administrator, Dr. Gerberding was Acting Deputy Director of National Center for Infectious Diseases (NCID), where she played a major role in leading CDC's response to the anthrax bioterrorism events of 2002. She joined CDC in 1998 as Director of the Division of Healthcare Quality Promotion, NCID, where she developed CDC's patient safety initiatives and other programs to prevent infections, antimicrobial resistance, and medical errors in healthcare settings. Prior to coming to CDC, Dr. Gerberding worked at the University of California at San Francisco (UCSF), where she was Director of the Prevention Epicenter, a multidisciplinary service, teaching, and research program that focused on preventing infections in patients and their healthcare providers.

Dr. Gerberding earned a B.A. *magna cum laude* in chemistry and biology and an M.D. at Case Western Reserve University in Cleveland, Ohio. Dr. Gerberding then completed her internship and residency in internal medicine at UCSF, where she also served as Chief Medical Resident before completing her fellowship in Clinical Pharmacology and Infectious Diseases at UCSF. She earned an M.P.H. degree at the University of California, Berkeley in 1990.

Dr. Gerberding has served on a number of national and international medical advisory boards. Her editorial activities have included appointments to the Editorial Board of the *Annals of Internal Medicine*. She was also Associate Editor of the *American Journal of Medicine*, and served as a peer-reviewer for numerous internal medicine, infectious diseases, and epidemiology journals. She has authored or co-authored more than 120 peer-reviewed publications and textbook chapters and contributed to numerous guidelines and policies relevant to HIV prevention, post-exposure prophylaxis, management of infected healthcare personnel, and healthcare-associated infection prevention and control.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH

Fiscal Year 2004 Budget Request
for Bioterrorism

Witness appearing before the
House Subcommittee on Labor, Health and Human Services,
Education and Related Agencies Appropriations

Elias A. Zerhouni, M.D., Director
National Institutes of Health

April 9, 2003

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH**

Statement of the Director

to the House Subcommittee on Labor-HHS-Education Appropriations
on the FY 2004 President's Budget Request
for Bioterrorism
April 9, 2003

Good morning, Mr. Chairman and Members of the Committee. Thank you for inviting me to testify concerning the Nation's investment in research at the National Institutes of Health (NIH) towards the development of safe and effective countermeasures to protect the American people against a broad range of potentially deadly terrorist threats. I am pleased to present the President's Fiscal Year 2004 budget request of \$1.625 billion for this effort, an amount that constitutes 5.8 percent of the total budget for NIH. The Fiscal Year 2004 NIH budget request for developing terrorism countermeasures includes the performance information required by the Government Performance and Results Act (GPRA) of 1993.

My goal today is to describe to you how the NIH, the Nation's premier biomedical research institution, is meeting a host of new challenges posed by threats of terrorism. In the face of this potential menace, the role of NIH is to enhance the Nation's preparedness by developing countermeasures to protect the health of civilians, a larger, more diverse, and more vulnerable group than military personnel. Our initial efforts focused heavily on developing countermeasures against microbes and toxins, an emphasis that reflects the lead role of the NIH in federally supported research on human infectious diseases. We are continuing and expanding these efforts; however, we have also recently begun to develop programs in three other areas of biomedical research where the NIH can make significant contributions to the national

counter-terrorism effort. These include the development of countermeasures for the threat of nuclear/radiological terrorism, countermeasures against chemical terrorism, and interventions to address the mental health complications of terrorism in all its forms on individuals and on society.

The scientific accomplishments and research programs I will describe today are built on the wealth of knowledge gained through long-term government investment in biomedical research, a research infrastructure that is unparalleled in the world, and the expertise of scientists from the United States and many other nations whose combined talents are making possible the advances of today and the discoveries of tomorrow.

OVERVIEW

The NIH has a long and productive history of responding to public health crises. In the 1980s and 1990s, several NIH Institutes, led by the National Institute of Allergy and Infectious Diseases (NIAID), combined their resources and scientific expertise to address a new and terrifying infectious disease caused by the human immunodeficiency virus (HIV). To increase the scope and power of its own research on HIV/AIDS, NIH collaborated with other Federal departments and agencies, among them the Department of Defense (DoD), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). The fruits of these research efforts, which continue to emerge today, include the co-discovery of the AIDS virus, the development of a diagnostic test for HIV infection, the development of therapies that greatly extend the duration and improve the quality of the lives of people infected with HIV, and interventions that dramatically reduce the transmission of HIV from mother to child.

Today, the United States is faced with a new challenge that demands a rapid response. This challenge appears different and more sinister, because it arises from the deliberate use of deadly microbes, toxins, chemicals, and ionizing radiation as weapons against civilians. However, the tools and processes we need to combat these forms of terrorism are familiar to us. They include fundamental research to discover the mechanisms of injury and disease, investigations that lead us to a better understanding of how humans respond to these potential weapons, and the translation of that fundamental knowledge into safe and effective countermeasures. Indeed, the experience and expertise of the NIH places us in a unique position to accelerate the development of countermeasures needed by Americans and people around the world to protect them against the threat of terrorism in the 21st century.

NIH RESEARCH ON BIOLOGICAL THREATS

The September 11, 2001, attacks on the World Trade Center and the Pentagon changed forever our collective thinking about the Nation's vulnerability to terrorist attacks. Superimposed on the events of September 11 were the first recorded cases of anthrax in the United States to result from intentional acts. Since then, the NIH, largely through the NIAID, has greatly expanded and accelerated its ongoing efforts to develop countermeasures against potential agents of bioterrorism.

The NIH biodefense research program is grounded in an intensive strategic planning process resulting in the development of the NIAID Strategic Plan for Biodefense Research, as well as comprehensive research agendas for Category A agents, and Category B and C priority pathogens. Prepared in consultation with blue-ribbon panels of experts, the research agendas delineate immediate, intermediate, and long-range plans for basic research and the development

of vaccines, drugs, and diagnostics. Category A agents are considered to be the most serious bioterror threats, and include smallpox, anthrax, botulinum toxin, plague, tularemia, and hemorrhagic fever viruses such as Ebola. Category B and C agents include many food and waterborne pathogens such as those that cause cholera, typhoid fever, and certain forms of dysentery. Thus, the development of countermeasures to protect the Nation's food and water supplies against a range of potential terrorist agents is included in the broad-based NIH biodefense research portfolio. Using the roadmap outlined in these agendas, NIAID has already begun implementing its research plan. A total of 46 biodefense initiatives were developed in Fiscal Years 2002 and 2003. The response from the scientific community has been strong; NIAID has seen a 30 percent increase in the number of grant applications, the vast majority of which are for biodefense.

Major Biodefense Research Accomplishments

The NIH response to the threat of bioterrorism has been unprecedented in its swiftness and scope. Aggressively managed, milestone-driven, interagency-coordinated efforts, and partnerships with industry have already resulted in important progress in basic research and in the development of biodefense countermeasures. For example, NIH is advancing the development of vaccines and therapies for smallpox. Last year, NIH-supported scientists demonstrated that the existing stocks of smallpox vaccine could be diluted five-fold and still retain the ability to stimulate the skin lesion "take" that is considered an indication of the vaccine's effectiveness. The discovery made it possible to expand and stockpile sufficient quantities of existing vaccine to vaccinate all U.S. civilians, should the need arise prior to the full availability of newer, licenced vaccines that are being procured for the Strategic National Stockpile. NIH is now

developing and testing next-generation, attenuated smallpox vaccines such as modified vaccinia Ankara (MVA) that can be used safely in people whose immune systems are compromised, in pregnant women, in people with skin conditions such as eczema, and in other vulnerable populations for whom the existing vaccine is not recommended. Additionally, NIH is testing antiviral compounds such as cidofovir, which is already approved by the FDA for treating an AIDS-associated opportunistic infection, as a potential therapy for smallpox, and is sequencing the genomes of smallpox and related poxviruses to identify potential molecular targets for drug and vaccine development.

Research on anthrax and Ebola is following a similar pattern of success. In collaboration with DoD, NIH has initiated tests of a next-generation, DNA-based vaccine for anthrax called recombinant Protective Antigen (rPA). Recently, NIH-supported investigators identified the site on a human cell that binds the anthrax toxin and have developed a compound that may block its lethal effects. The information gained through these and other studies will likely hasten the development of new drugs to treat anthrax. Furthermore, NIH intramural scientists developed a DNA-based vaccine candidate against Ebola virus that protects monkeys from infection with the deadly virus. This Ebola vaccine candidate will soon enter human clinical trials.

Other advances in biodefense are being facilitated by the detailed information about pathogens that can be gleaned from determining their genomic sequences. The field of pathogen genomics has made remarkable progress in recent years: sequencing of the genomes of more than 100 pathogens is complete or nearing completion. Among them are approximately 30 different Category A, B, and C agents, including multiple strains of the anthrax bacterium, the

Category B pathogen *Salmonella typhi* (typhoid fever), and the Category A agent *Yersinia pestis*, which caused the infamous Black Plague of the 14th century. This genomic information is being used to inform the development of new antimicrobials, vaccines, and diagnostics.

Major Biodefense Research Initiatives and Future Plans

The NIH biodefense research agenda is comprehensive, broadly based, and forward-looking. Initiatives to address the agenda include studies to understand the basic biology of microbes and the mechanisms by which they cause disease, to identify critical factors in the human innate and adaptive immune response to these microbes, and to develop new and improved products that can prevent and treat diseases caused by Category A, B, and C agents. Future progress in biodefense research also depends on the availability of specialized resources that enhance the NIH research infrastructure. Initiatives in Fiscal Year 2003 include the establishment of a nationwide network of Regional Centers of Excellence for Biodefense and Emerging Infectious Disease Research, and a system of Regional and National Biocontainment Laboratories. The new centers and laboratories will include a small number of Biosafety Level-4 (BSL-4) laboratories, which have the containment safeguards necessary to study highly pathogenic organisms. These facilities will serve as national resources for biodefense research and product development, as well as for the study of other emerging diseases such as influenza and West Nile virus. We are also expanding greatly our capacity for large-scale genome sequencing, and developing new technologies to mine the wealth of data generated from genomic research.

A requirement for success in the NIH biodefense research agenda is the engagement of private industry in product development. Unfortunately, many biodefense products provide

insufficient incentive for private-sector engagement because there may be no viable market. Within the limits of current statutory authority, NIH continues to develop new and innovative approaches to public-private partnerships to overcome such obstacles. However, we see Project BioShield as crucial for ensuring the optimal involvement of industry, because it will create a secure source for government procurement of the products that NIH develops. It will also greatly strengthen our ability to respond to the many challenges associated with biodefense research and development by providing streamlined authority, increased flexibility in awarding grants and cooperative agreements, expedited peer-review procedures, bolstered authority for acquisition, construction, and renovation of facilities, and greater flexibility in hiring technical experts.

NIH RESPONSE TO NUCLEAR/RADIOLOGICAL AND CHEMICAL THREATS AND THE PSYCHOSOCIAL IMPACT OF TRAUMATIC EVENTS

Over the past several months, we have begun to explore expansion of these first-priority efforts, in order to assist in addressing several other areas of concern: nuclear/radiological terrorism, chemical terrorism, and the psychosocial impact of traumatic events. As we did in planning our efforts in microbial bioterrorism, we first convened expert panels to help us understand the general landscape of the problem and the research needed to address it. On February 26, 2003, NIAID convened a meeting that included scientists affiliated with the National Cancer Institute, the Armed Forces Radiobiology Research Institute, the National Academy of Sciences, other government agencies, and academia, to identify immediate, intermediate, and long-term priorities for research needed to develop countermeasures against

nuclear/radiological terrorism. Then, on March 19, again under the leadership of the NIAID, we convened a panel of experts that included representatives of the National Academy of Sciences (NAS), academia, industry, other federal agencies, including the DoD, and multiple NIH Institutes and Centers. This panel's charge was to identify gaps in scientific knowledge about chemical injury and repair amenable to biomedical research, and to describe priorities for research and development of medical countermeasures. Both of these consultations were extraordinarily productive and provide a framework for agendas of NIH-supported biomedical research and countermeasure development that contribute to the national effort.

The third area of concern relates to the psychosocial trauma of disasters and mass casualty events. The National Institute of Mental Health (NIMH) has a program committed to research related to mass casualties and trauma. Within several months of the World Trade Center and anthrax attacks, the NIMH expedited the award of grants to study resulting mental health needs and convened, with other agencies, a major national workshop on mental health needs in disaster response. Building on this initial effort, the NIMH is exploring additional behavioral/mental health research aimed at two problems, treatment of trauma in individuals, and communication with the public during disasters and other traumatic events.

Our plan in each of these areas is to develop research agendas within the NIH Institutes relevant to them. We will, in the process, work closely with colleagues elsewhere in government, including especially the Department of Homeland Security, and the NAS.

Finally, to help ensure that these efforts are well coordinated, I have established a Trans-NIH Bioterrorism Committee. The committee, chaired by NIAID Director Anthony S. Fauci, M.D., and reporting to me regularly and as needed, will coordinate activities, assess progress

toward the development of countermeasures across the NIH, serve as the NIH focal point for liaison and communication with other agencies, and focus on continuing to develop and monitor our comprehensive biodefense research agendas.

I am confident that this program of research and countermeasure development, growing from our efforts in biodefense, will provide health benefits that encompass but also extend far beyond protection from deliberate acts of terrorism. I am pleased that NIH can play a role in these important areas of national security.

Elias A. Zerhouni, M.D.
Director
National Institutes of Health
U.S. Department of Health and Human Services

On May 20, 2002, Dr. Elias A. Zerhouni, 51, began his tenure as the 15th Director of the National Institutes of Health.

Among his noteworthy achievements since becoming Director, Dr. Zerhouni has named directors for three Institutes—the National Institute of Mental Health (Thomas R. Insel, M.D.), the National Institute on Alcohol Abuse and Alcoholism (Ting-Kai Li, M.D.), and the National Institute on Drug Abuse (Nora D. Volkow, M.D.). He also named a new NIH Deputy Director (Raynard S. Kington, M.D., Ph.D.) and a new director of the Office of Technology Transfer (Mark L. Rohrbaugh, Ph.D., J.D.)

Dr. Zerhouni initiated the creation of a new research vision for the NIH which focuses the attention of the biomedical research community on new pathways of discovery, research teams for the future and the re-engineering of the clinical research enterprise.

He has also overseen the completion of the doubling of the NIH budget.

Prior to joining the NIH, Dr. Zerhouni served as executive vice dean of Johns Hopkins University School of Medicine, chair of the Russell H. Morgan department of radiology and radiological science, and Martin Donner professor of radiology and professor of biomedical engineering.

His research in imaging led to advances in Computerized Axial Tomography (CAT scanning) and Magnetic Resonance Imaging (MRI) that resulted in 157 peer reviewed publications and 8 patents.

Since 2000, he has been a member of the National Academy of Sciences' Institute of Medicine. He served on the National Cancer Institute's Board of Scientific Advisors from 1998-2002.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
BIOGRAPHICAL SKETCH

NAME: Kerry N. Weems

POSITION: Deputy Assistant Secretary for Budget

BIRTHPLACE: Portales, New Mexico

EDUCATION: B.A., Philosophy, New Mexico State University, 1978
BBA, Management, New Mexico State University, 1978
MBA, University of New Mexico, 1981

EXPERIENCE:

January 24 - Present	Acting Assistant Secretary for Budget, Technology and Finance
June 2002 - Present	Deputy Assistant Secretary for Budget, HHS
2001 - 2002	Acting Deputy Assistant Secretary for Budget, HHS
1996 - 2002	Director, Division of Budget Policy, Execution and Management, HHS
1991 - 1996	Chief, Budget Planning Branch, HHS
1988 - 1991	Program Analyst, Office of Budget, HHS
1983 - 1988	Program and Budget Analyst, HHS (Social Security Administration)
1981 - 1983	Staff Member, United States Senate

HONORS AND AWARDS:

2001	Presidential Rank Award
1995	Secretary's Distinguished Service Award
1993	HHS Senior Management Citation

Written Statement by
Elizabeth M. James Duke, Ph.D., Administrator
Health Resources and Services Administration
on
HHS Efforts to Prepare Against Bioterrorism

Before the House Subcommittee on
Labor-HHS Education Appropriations
United States House of Representatives

April 9, 2003

Mr. Chairman, Mr. Obey and Members of the Committee:

I am pleased to appear before you today to discuss the efforts of the Health Resources and Services Administration to further prepare the nation's health care system and public health system for possible bioterrorism attacks. As Assistant Secretary Hauer has outlined, the focus of HRSA is to increase the preparedness and response capability of hospitals and health care entities and to integrate our health care and public health systems, so that together we can prepare for and detect a bioterrorist attack and provide appropriate health care treatment and services.

The President's Budget for HRSA includes two targeted programs that will assist the Nation in preparing for possible bioterrorism and other attacks: the Hospital Preparedness Program, and the Bioterrorism Training and Curriculum Development Program. A total of \$578 million is requested in the Public Health and Social Services Emergency Fund to expand these programs in FY 2004.

Our major initiative is the Hospital Preparedness Program, begun in FY 2002. \$518 million, an increase of \$3 million, is requested to continue cooperative agreements with health departments in States, territories and our three largest municipalities. These cooperative agreements provide funds to improve the ability of state health departments, hospitals and other health care facilities to prepare for and respond to bioterrorism and other public health emergencies. Some funds are to be used by the health departments to plan and coordinate hospital preparedness. The recipients of these cooperative

agreements are required to allocate 80% of the federal funds to hospitals and other health care facilities to expand their capacity to care for victims of bioterrorism and other public health emergencies. Hospitals and other health care facilities may use the funds to upgrade their ability to respond to bioterrorism and other mass casualty events by developing improved approaches to dealing with a surge of patients, developing regional consortia to pool limited resources and utilize such resources to the best advantage in a systems-wide approach, and improving their communications capability.

In FY 2003, \$498 million is available for Hospital Preparedness cooperative agreements. Secretary Thompson recently announced that up to 20 percent of those funds will be made available to States on a rapid release basis if the States need funds to:

- Support their smallpox vaccination activities for health workers and emergency responders.
- Support activities already approved in 2002 state plans which need additional resources now.
- Enhance or intensify critical activities already approved under last year's state plans.
- Accelerate timelines for these critical activities.

In addition to the original 59 grantees (the 50 States, the District of Columbia, Puerto Rico, four territories (Virgin Islands, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands) and three municipalities (New York City, Chicago, and

Los Angeles County), we will be making funds available this year to the three freely associated states of the Pacific, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

The Program Guidance for FY 2003 provides new or expanded emphasis in such areas as development of state plans to address surge capacity, emergency medical services, special needs of the pediatric population, and mental health services. With the substantial increase in funds in FY 2003, there will be an increased emphasis on hospital resource and infrastructure enhancements. One new focus is to help hospitals improve their infection control capabilities by upgrading facilities for isolation and treatment of individuals who have a communicable disease or are at high risk due to exposure. A second focus is to ensure adequate hospital laboratory surge capacity and integrate such capability with public health labs to identify and report on biological, chemical and radiological agents that might be used by terrorists. A third focus is to assist hospitals, outpatient facilities and emergency medical services with the purchase of personal protective equipment and well-equipped mobile or fixed decontamination facilities. There will also be an emphasis on methods for improving communications capacity among hospitals, other health care entities and public health departments.

The States are making good progress in completing their needs assessments and in implementing their high priority components. For example, based on patient flow patterns to medical centers, Tennessee developed six Hospital Bioterrorism Planning

Regions and is developing regional hospital plans based on these regions. Tabletop exercises that will test the capability of hospitals in each region to respond to a bioterrorism scenario and accommodate a surge of 500 patients will be conducted this year. In Pennsylvania, some 200 hospitals that received the Hospital Emergency Preparedness Needs Assessment participated in the assessment. Initial review shows that most hospitals currently have in place emergency plans for the delivery of essential goods and service, but only 40% have plans that address the reconfiguration of hospital space for isolation of communicable diseases and treatment of infectious disease epidemics. The funds made available in FY 2003 will be used to help improve this response capability.

The second targeted program is the Bioterrorism Training and Curriculum Development Program, which began in FY 2003. The President's Budget includes \$60 million, an increase of \$32 million, to expand this important program, which will ensure that the public health and healthcare workforce is properly equipped with the skills, knowledge and networks to address possible bioterrorism attacks. The goals of this program are the development of a healthcare workforce that possesses the knowledge, skills and abilities to: (1) recognize indications of a terrorist or public health emergency event in their patients; (2) treat their patients and their communities in a safe and appropriate manner; (3) participate in a coordinated, multidisciplinary response to terrorist events and other public health emergencies; and (4) rapidly and effectively alert the public health system of such an event at the community, state and national level.

HRSA has extensive experience in working and collaborating with public and private health professional organizations and academic health centers to develop new and innovative training programs that meet emerging needs. The agency also has experience using educational incentives to influence curricular change so that undergraduate, graduate and continuing education programs meet emerging national needs.

HRSA will continue to operate two other complementary programs, which are also requested in the Public Health and Social Services Emergency Fund: the Emergency Medical Services for Children Program (EMSC), and the Poison Control Center Program. A total of \$40 million is requested to maintain these programs.

The EMSC program is designed to ensure state-of-the-art emergency medical care for ill or injured children and adolescents. The program provides grants to States to improve existing EMS systems and to schools of medicine to develop and evaluate improved procedures and protocols for treating children. If new protocols are developed for bioterrorism or chemical agents, we need to adapt them for use with children and disseminate them through this program.

Poison Control Centers are a vital part of the continuum of necessary emergency services needed by all Americans facing the threat of bioterrorism and can serve as part of the nation's surveillance and first response system. During the anthrax incident in

Florida, the Poison Control Centers were able to answer many of the public's questions about what was going on and to provide accurate information about anthrax.

With this set of targeted and complementary programs, we believe that we are strengthening the ability of the nation's public health system and hospitals to prepare for biological and chemical attacks. These programs will also expand the surge capacity of hospitals to care for large numbers of patients that would result from a mass-casualty incident.

Mr. Chairman and members of the Committee, I would be pleased to address any comments or questions you may have on the specifics of the programs I have outlined.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Biographical Sketch

NAME : Elizabeth M. James Duke, Ph.D.

POSITION : Administrator
Health Resources and Services Administration (HRSA)

BIRTHPLACE : Philadelphia, PA.

DATE : 7/14/36

EDUCATION : B.A. Douglass College, New Brunswick, NJ
M.A. Northwestern University, Evanston, IL
Ph. D. George Washington University, Washington, DC

EXPERIENCE :

03/02 - Present : Administrator, HRSA

03/01 - 03/02 : Acting Administrator, HRSA

11/97 - 03/01 : Deputy Assistant Secretary for Administration
Administration for Children and Families, (ACF)
Chief Financial Officer, (ACF)
Chief Grants Management Officer, (ACF)
Chief Information Officer, (ACF)

1986 -1997 : Acting Assistant Secretary and Principal Deputy Assistant
Secretary for Management and Budget, HHS

BACKGROUND INFORMATION:

In addition to other responsibilities, Dr. Duke also had oversight of major organizational changes carried out within the framework of the Department's Continuous Improvement Program, reinvention efforts to streamline HHS personnel as mandated by Executive Order 12839, regional restructuring and transfer of functions, work process reengineering for all Staff Divisions of HHS, and restructuring HHS following the Social Security Administration's independence.

Mr. REGULA. I think it is quite encouraging progress that the Department has made in responding to a challenging time in our Nation's history. I was particularly impressed with the fact that you seem to be getting internally a lot of cooperation among the various agencies, all of whom have a piece of it and yet collectively are part of this BioShield. I have been interested in making the healthcare delivery system seamless, and I would be interested whether you are making some progress in doing that so that the health commissioner and small community in Ohio and the State health commissioner and CDC and all are on the same page when it comes to a threat.

HHS INTERNAL AND EXTERNAL COMMUNICATION AND COORDINATION

Mr. HAUER. Yeah. One of the things that we have been very aggressive in doing is enhancing communication with the State and local health departments. CDC has done an excellent job in outreach, and I think a perfect model for this has been the magnificent job that Dr. Gerberding and her staff have done on SARS. First of all, aggressively dealing with SARS as the first sense that something was happening here in the United States came to light, CDC was very aggressive in getting information out and in talking with State and local health officers.

CDC has a practice now, we are involved in the conference calls, but at least once, usually three times a week, they have conference calls with State and local health officers to bring them up to date on what is going on with the smallpox program, on what is going on with SARS, on other hot issues, to listen to their issues and just to communicate with them.

One of the efforts the Secretary asked us to move forward with very recently was to get the State health commissioners and members of their staffs security clearances so we could share threat information with them. The public health community in this country has never been engaged from a national security perspective. We have to recognize that this is a different day, and that the public health community is an integral part of national security, and we have to—one of the reasons we are pushing so hard on the public health community having 24/7 coverage is historically that was not the case.

So we have moved forward on a number of fronts to engage the public health community to ensure that they are a part of the process every step of the way.

Mr. REGULA. As you know, the subcommittee will be visiting your agency when we return from the Easter recess, and you might tell the committee a little bit about what you have been able to do in developing an information system in your Department that will certainly be useful to all agencies and will make the whole process more seamless.

Mr. HAUER. I would be happy to.

As you saw during your visit, we have developed probably the state-of-the-art command center in Washington, D.C., now that is interoperable with every State, local, city agency within the tristate region around here. We can communicate during an emergency by simply dropping a box into any city or county in the country, and we can then communicate on their radio frequencies in an inter-

operable fashion, which has been one of the problems in dealing with managing emergencies in this country for many years is the lack of interoperability. We are truly interoperable now.

We have the capability to do multiple video conferences and bring up to 10 different locations. During SARS Julie and I do a conference call every morning at 10:15 with Julie at CDC, me up at Washington, and very often somebody from PAHO or World Health in Geneva on as well, all of us looking, talking with each other, interacting and sharing information. In all the years I have been in this business, information-sharing is what makes you or breaks you.

Our command center has probably the most sophisticated—Julie will take issue with this because she just opened a command center as well, and she likes to think her command center is now—it is newer than ours, but I don't know that it is more sophisticated. But we are sharing our programs.

Dr. GERBERDING. Ours is bigger.

Mr. HAUER. That is right.

But this was all added to just a terrific intra-agency communication and that intra-agency communication makes it easier for them to talk with one voice to all the health departments around the country and for them to get timely, accurate and consistent information so they can take action at the State and local level.

When you come over after the recess, we will show you some new modeling. We are probably the only agency in town that is doing three-dimensional plume modeling now that we have just gotten on board since you were over there. That is some of the most dynamic plume modeling available to predict the impact of chemical and biological agents.

Mr. REGULA. It is impressive. I might, if you would, just talk about the push packs, because that would give the public a sense of confidence of the ability of HHS and NIH and CDC and so on to respond to any crisis. And I was impressed with what you are doing on that. So if you could just—

STRATEGIC NATIONAL STOCKPILE

Mr. HAUER. Sure. We have 12 push packs strategically located in basically secret facilities that are very well secured throughout the country. We have the ability to move the push packs pretty much anywhere in the country within 6 to 12 hours, depending on how we move it and the distance we have to move it. Each pack contains about 50 tons of medical material including antibiotics and respirators, support equipment. Because of the concern of SARS, botulinum, things that require respiratory support, we have added additional respirators to the push package.

The push package is not static. We continue to look at the threats, and we continue—this is one of the things that NIH is working very closely with CDC on. As we look at threats and the potential for new drugs to be used against these threats, new countermeasures, we evaluate them very quickly to determine whether they should be put in the push package.

There are some things that are best not put in the push package. Antidotes for organophosphates are best in the hands of police and firemen because they need to be used in such a short period of

time. But we have purchased those through the push package, and most recently CDC distributed to over 60 fire departments in the country material from the push package so they could have it on their ambulances so that it was available for use within 15 or 20 minutes, which is when it is best used.

Mr. REGULA. So this means that local communities have the ability to call on these resources if there is any kind of a crisis.

Mr. HAUER. Absolutely. We can either pre-stage the push packages in the event of a special event, as we did for the Olympics, for other special events that we have around the country, or we can respond with the push pack within 6 to 12 hours, and again, depending on the location, we had the push packages up in New York City in under 7 hours.

Mr. REGULA. Are local health departments aware of this resource, and can they call upon them?

Mr. HAUER. Yes. One of our requirements as part of the grant money that the States receive is to have a plan in place for receipt of the push package, but also distribution of the antibiotics that are in the push package. CDC added to that requirement as we became more and more concerned about smallpox vaccine by ensuring that one of the requirements was that they have a plan in place for mass vaccination of the population after the detection of a smallpox event. So once we release the vaccine from the National Pharmaceutical Stockpile, the cities and States have to have a mechanism to receive it and to distribute it.

Mr. REGULA. I have a lot more questions, but I want to get to the committee members.

So, Mrs. Northup.

Mrs. NORTHUP. Thank you.

I am interested in the designation of a lab in every State. As I understand it, one of the first things that happened was we designated a lab in every State, and I wondered it seemed to me that the lab was chosen in Kentucky, I believe in Frankfort. Maybe that is because where the State lab is, that is where the State capital is. But Louisville obviously has the largest population. I heard a lot of complaints from our local responders because they felt like it is far away, it is remote, there isn't even a commercial airport in and out of Louisville. There is not the sophistication that already exists at the University of Louisville or the University of Kentucky's medical school.

I just wondered are we going to have to bring all these labs up to a certain capacity? They will still be—if the State capital is in a remote area, they will still be in a remote area. There will still be a lack of transportation in and out of those areas. If that makes sense, I realize that is where the governmental connections are, but if that is really a good choice.

Dr. GERBERDING. The Laboratory Response Network that you are talking about started out of State health laboratories, so that is the reason for its genesis. But through the last year we have been expanding it to include a broader spectrum of laboratories, and actually have brought all of the labs in the network up to a certain level of capacity and sophistication rather than the more layered approach that we had, level A, level B, level C, in the past.

So there are now evolving a set of laboratories, so-called central laboratories, many of which are associated with hospitals or laboratories that can be brought into the LRN. So we are looking at how to do that strategically and make sure we have the coverage that you are talking about so it is convenient to move samples around.

Another important aspect of this is surge capacity. We learned during anthrax that it is not good enough to have one good lab, you to have a system for moving specimens from one place to another, moving lab technicians. We have a great interest on the part of the academic community in Kentucky and a lot of other places that would like to contribute to the LRN. I think that is a priority for this coming year.

Mrs. NORTHUP. I guess I wonder if you are not going to be struggling with the political aspects of it now, I can't imagine the lab in Frankfort deciding that, yes, they are going to take sort of a second tier and let the lab at the University of Louisville or the University of Kentucky labs that are already much, much more sophisticated than the lab in Frankfort, and, of course, have access to much more sophisticated transportation in and out and so forth, whether they are going to let go. And whether you are going to—if your relationship already tends to be with the lab in Frankfort, are you going to find that a difficult transition to do?

Dr. GERBERDING. We have had success with it in other jurisdictions and think that it is not a matter of substituting one lab for another, it is a matter of adding additional labs into the system and making the whole network effective. So I am not too worried about the politics of the situation. I am more worried about the speed with which we can bring everybody up to date.

One of the real challenges is reagents, because we are making the reagents for a number of these tests as we go. For example, right now we are trying to make reagents for SARS so we can get this material out to the laboratories very quickly. And participation in the network does involve coming to CDC and being trained to do techniques exactly the same way in every laboratory and every place so when we get a result in one place, we know it means the same that it does someplace else. That is just a matter of time and capacity development.

But I think you are absolutely right. Labs that are already capable of doing sophisticated Polymerase Chain Reaction (PCR) analysis and so forth would have a shorter learning curve than those that are starting from a different place. So—

Mrs. NORTHUP. Specifically we have a huge mail processing plant in Louisville. They had a number of anthrax scares where it was actually shut down. Every single sample had to go to Frankfort, which again, like I said, doesn't even have an airport. And back right there in Louisville is a much more sophisticated lab that could have provided just almost immediate turnaround and results.

Dr. GERBERDING. That makes sense.

Mrs. NORTHUP. I really ask you, I am not necessarily reassured that you are just going to add more labs, because I don't know that we can support on a cost basis, you know, bringing up the lab in Frankfort to a certain level and adding labs that maybe are already in place and able to act. I mean, I just—I think at some point you have to be selective, and not everybody is going to like the answer.

Dr. GERBERDING. Thank you.
Mr. REGULA. Mrs. Lowey.

PROJECT BIOSHIELD

Mrs. LOWEY. Thank you, Mr. Chairman, and thank you, Secretary Hauer and your distinguished panel for your important work. I would like to ask a few questions about Project BioShield. First of all, with regard to the funding, I don't understand why the funding has to bypass the annual appropriations process led by our distinguished Chairman. There is no question in my mind that we care as much about Project BioShield in your agenda as all the distinguished people in the administration. So I am very confident just as we forward-fund PBS, or if the contracts are presented in 2004, that we can't immediately provide the funding. So that is the first question.

Secondly, at the hearing of Homeland Security that Dr. Fauci and Secretary Thompson attended and informed us about Project BioShield, there were two questions that have not been sufficiently answered for me. One is, and Dr. Fauci probably could respond to this, there is no question at the hearing that—directed by yourself and others, that you could aggressively work to get the research done at NIH or appropriate institutions. However, the problem was the pharmaceutical companies, as explained to us, just didn't see enough profit in it, and that you were concerned about how you were going to get these vaccines produced efficiently, because Secretary Thompson made that point, the large pharmaceutical companies wouldn't find this attractive.

I find this very disturbing, since they manage to make profits with so many of their other products, that there wouldn't be a better way for to us orchestrate this at the NIH. Dr. Zerhouni or Dr. Fauci could respond to that, since the research to me is the most challenging portion, that we couldn't develop laboratories or whatever and get this done, and it is disappointing to me that the large pharmaceutical companies, according to the information you presented, wouldn't be interested.

And thirdly, Project BioShield requires, as I understand it, another process that you say is more efficient for approving these drugs. I have seen this, frankly, with MCA and other initiatives on the part of the administration. We have been fortunate in having an FDA process that has produced some of the greatest drugs in the world. If there are inefficiencies, if they can't do it expeditiously, I don't understand for the life of me why we can't improve the process, make it more efficient. Why do we have to create another process? And I have seen a constant pattern of this in the administration; if, in fact, the bureaucracy is not functioning, well, let's just create our own. I am not sure the "own" will function any better, and I don't know why we can't improve upon this, because I have had many calls from constituents and others who feel that the FDA is not operating as expeditiously as it should be.

So if perhaps whoever would like to contribute to the three questions, I would be most appreciative. I congratulate you on Project BioShield. I am very enthusiastic about it, as I am sure we all are. I am just concerned about the process.

Dr. FAUCI. Thank you for the question, Mrs. Lowey.

As we discussed at the last hearing, but I will try to expand on it briefly, we fully appreciate the perspective that you have, if companies do so well in other arenas. Why they would not be willing to take the chance and go ahead and get involved in developing, particularly in the advanced development stage, countermeasures for agents of bioterror and other chemical, radiological threats. The situation, the reality is that there is a push and a pull mechanism, as I had mentioned at the hearing. The NIH works at the "push" end of the mechanism. We have been putting research funds into getting proof of concept for things that may not necessarily be attractive to the industry for the simple reason that despite the fact that many of them make a lot of money, if they don't see a market for or at least a modest profit for a particular endeavor, they will naturally, because of their responsibilities to their board, to their stockholders or whenever, pursue something that has a guaranteed market. And we just know that as a matter of fact.

Now, the issue that we are faced with that—either when we say we need this particular countermeasure, which BioShield would say that the DHS Secretary would assess the threat and the HHS Secretary would go about with the CDC and the NIH and others about getting this material forward—when you talk about a company that has no real interest in doing that, and you want to bring them in, we have many examples of people who come to us and say, we would be willing to take the risk and even share a risk with you, and we are not afraid of failure, but what we are afraid of is succeeding in developing a product and then finding out 2 years down the pike that nobody wants to buy it.

And they feel very uncomfortable about being at the mercy of the vicissitudes of the appropriation process. We all have a great deal of faith in the appropriation process, but unfortunately the companies who need to be putting up front the 150-, \$200,000,000 to do the advance development, they would like to have assurance that if they deliver the product, that we will pay for it. And this would have to be in a situation in which we could advance 2 or 3 years down the pike, say, yes, if you deliver it, we will do it.

Now, the important part about BioShield that often gets misunderstood is that you are not paying for something that you don't get. It is different than other procurement types of procedures. We are going to be paying for things that will ultimately be licensable and licensed and in the stockpile. So it is really a matter of instilling in them the confidence that down the pike there will be something for them. That is the first part.

The second part that you asked was about the FDA; again, sometimes misunderstood. We are faced not infrequently now with bio-defense with the situation where you have a product that either is safe and certainly effective, but for one technical reason or another is either not licensable, or if it goes through the normal process of licensure, that it would take an additional year or so. In an exigent situation, so we are not talking about this as an alternative pathway for the FDA, we are talking about this as an emergency circumstance, where we have a countermeasure available and the logistics of an unlicensed product to distribute it under another mechanism, which is called an investigational new drug, IND, if you are going to give it to 2,000, 3,000 people putting it through,

an investigational new drug, mainly signing the consent form, all of the paperwork that is associated with it, logistically you can do—if you have to vaccinate 10 million people, there isn't a chance that you are going to be able to do that under an investigational new drug.

So what the proposal says is that something between a full licensure and something that is an investigational drug, where you can under certain emergency circumstances for a 1-year period, so it isn't an indefinite period, to meet the emergency, make that available, provided the risk/benefit ratio is in place; namely, the risk of the particular countermeasure is not nearly as great as the risk of not doing it. That was the reason for that component of BioShield.

Mrs. LOWEY. I probably don't have time to continue this discussion.

Mr. REGULA. We will have another round.

Mrs. LOWEY. With the FDA I just don't understand because the problem of moving products through is not a new one. So I just don't understand why it can't be made to function to deal with the current challenge, frankly.

Mr. REGULA. You will have another opportunity to challenge that.

Mr. Wicker.

SMALLPOX VACCINE

Mr. WICKER. Thank you, Mr. Chairman.

Secretary Hauer, let me ask you, you said that 67 million doses of the cell culture-based smallpox vaccine are already in the stockpile. Do I take it there are two kinds of smallpox vaccine, the VIG and the cell culture?

Mr. HAUER. No. The cell culture-based vaccine is a new vaccine that we have just begun making. We began that process back in October, started taking delivery of the vaccine late last year, and it is a different vaccine than the vaccines that were historically used, otherwise known as dry vacs, which is a—

Mr. WICKER. Sounds like two kinds to me.

Mr. HAUER. Yes. VIG, on the other hand, is what we are buying to treat the potential adverse effects of the vaccination.

Mr. WICKER. I see. Okay.

How many people have received—how many Americans have received a smallpox vaccine since the terrorism threat?

Mr. HAUER. Since we began the program, we are up to about 30,000.

Mr. WICKER. Thirty thousand.

Mr. HAUER. Thirty thousand.

Dr. ZERHOUNI. Civilians.

Mr. WICKER. Thirty thousand civilians.

Are those all volunteers, or are some people required to do that?

Mr. HAUER. Those are all volunteers.

Mr. WICKER. How many noncivilians?

Mr. HAUER. The DOD program has been very aggressive. They were close to 400,000.

Mr. WICKER. So out of those 430,000 Americans who have had the vaccine, have there been any adverse effects?

Mr. HAUER. There have.

Mr. WICKER. Any deaths?

Dr. GERBERDING. Let me step in here. The situation with the vaccine for the civilian program is that we have had the development of a new adverse effect that we weren't previously associating with the vaccine, and that is an inflammation of the heart and the lining around the heart, so-called myopericarditis. That has been observed in the military vaccination program, too. It is occurring about 1 in every 25,000 people who receive the vaccine.

Mr. WICKER. This wasn't observed in the earlier decades when people like me received—

Dr. GERBERDING. This was not an observed effect with the vaccine we are using here. There was an association of this with vaccines that were used in other countries at a higher dose than what we had typically used in the United States. So we were not aware of this adverse event when we started the program. We have subsequently advised people to be aware of it and include it in the consent process.

In addition to that, there is one heart complication that is generally mild, although there has been one very serious case. Also, there are heart attacks and other ischemic-type heart events that have occurred in people after vaccination. We don't think those are directly related to the vaccine because some of these people were at high risk for heart attacks anyway, but we are not sure. So we are screening people with high risk for heart disease out of the voluntary program to avoid exposing them to any risk if it is present.

Mr. WICKER. Okay. My general question is this: Any member of the panel, paint me the most likely scenario of a successful terrorist attack involving smallpox, either on a large population like Washington, D.C., or a medium-sized city or small town where the effect would still be devastating?

Dr. GERBERDING. Do you mean successful from the standpoint of the terrorist?

Mr. WICKER. Yes.

Dr. GERBERDING. The thing that we are most worried about is an aerosol release of smallpox where the virus is created and placed into some form where it could be spread in the air through very fine particles; for example, with an airplane flying over with some aerosol release device into a large group of people, which would simultaneously expose large numbers of people in a given community and wouldn't necessarily be noticed until the first case of smallpox occurred. This would require us to have a very sophisticated and reliable detection system so that when the first case appeared, we would immediately recognize it; and second, a capacity to in that vicinity immunize large numbers of people very, very quickly.

It is that concern about that scenario that led us to develop the pre-event vaccination program so we would have a greater likelihood of being able to get people vaccinated very quickly to protect them. Remember that you can vaccinate within 2 to 4 days after an exposure and still benefit the person who was exposed and then either prevent smallpox altogether, or at least reduce the severity of the exposure.

Mr. WICKER. To your knowledge, has that ever occurred anywhere on the face of the Earth?

Dr. GERBERDING. We have not ever been able to document an aerosol release of smallpox as a terrorism event anywhere.

Mr. WICKER. How about an aerosol release of other biological terrorism?

BIOTERRORISM RESPONSE PLANNING

Mr. HAUER. Yes. The aerosol release we are most aware of for biological agents was anthrax in Sverdlovsk in 1979. It was an accidental release, and—but it killed a number of people. It was a rather crude release.

The potential to release small quantities in small cities and in multiple cities is not as difficult as one would think. Julie had mentioned the whole notion of an airplane and releases over the city. We do modeling on several different types of releases.

One of the other concerns we have is just small numbers of people being impacted in 5 or 10 cities over multiple days in closed environments like subways, office buildings, where you have foci in a number of different cities, and that could be quite troubling as well in the ability to respond because one city, everybody focuses their resources there.

Our planning as we have looked forward has been the multicity approach. How do we mobilize resources so if we have to respond to 5 or 10 cities around the country and do mass vaccination of 5 or 10 cities, or provide health care in 5 or 10 cities, and we have had to look at that as well as a major release in just one jurisdiction as well.

Mr. WICKER. Do I still have a minute or two?

Why smallpox then, if anthrax has been released?

Mr. HAUER. Anthrax has been released, botulinum has been released, the Aum Shinrikyo on nine different occasions released various chemical and biological agents both in Matsumoto and Tokyo. They looked, they tried using anthrax on several occasions and were unsuccessful because of the thermodynamics of the environment they were in.

The reason we are so concerned about smallpox is that anthrax by and large is treatable. There is no treatment for smallpox. Smallpox is a contagious agent, unlike anthrax, and the potential for not just the disease itself creating an enormous problem, but the economic impact, the psychological impact on this country could be enormous. So we felt that as we looked at the threat agents, botulinum, smallpox, anthrax, tularemia and a host of chemicals on the chemical side were things that we had to really focus on and focus on quickly and aggressively. And that is what the Secretary has had us doing for the last 2 years as we hear about other threat agents, or most recently there has been concern about cyanide and ricin. We have looked at it. We have evaluated it from a threat perspective. We have evaluated it from a response perspective. Quite frankly, ricin is not the agent of choice for dissemination from an airplane. There is no treatment for ricin. On the other hand, botulinum concerns us greatly.

So we look at this from a number of different perspectives as we evaluate how we are going about developing this stockpile, how we are developing countermeasures, how we are putting our research

and development dollars into the pipeline into what NIH is doing, and that is all part of the equation as we move forward.

Mr. REGULA. Mr. Kennedy.

Mr. KENNEDY. Thank you.

Welcome.

On March 20th, 1995, chemical nerve agent sarin was released in five locations within the Tokyo subway system. Medical literature shows that of the 505,000 people who swamped Tokyo hospitals after the attack, only 20 percent actually suffered from physical symptoms due to exposure to the chemical agent. Eighty percent were determined to have physical symptoms secondary to psychological distress.

In the anthrax attacks in the fall of 2001, here in Washington, emergency rooms were overwhelmed as well. This occurred despite Hill staffers being told that no-cost treatment centers—and many of them were set up across the Hill for them to go to.

With this said, it doesn't take much imagination to conjure up a possible hysteria on the public and the part of the public if there was a terrorist attack here. Up until just 2 minutes ago, I hadn't heard you say psychological in your whole testimony, which concerns me. If we had a biological or chemical attack, emergencies would be overrun, potential disaster situations would be set up where the ability for us to hold together a population would be untenable.

A retired Army general recently met with me, said that a crisis of this is the worst type of training ground for people. In other words, he repeatedly said critical necessity for our Nation to become psychologically prepared for potential biological attack, and numerous experts studying terrorism with weapons of mass destruction predict that the event of a biological attack on the United States, psychological casualties will outnumber physical casualties by a ratio of easily 4 to 1.

With all that said, would each of you comment to this committee about what you believe as individuals and what you are doing as institutions to adequately prepare to deal with the psychological fallout from a biological attack; and, two, if you don't believe that we are adequately prepared, would you comment as to what you think we need to do in order to prepare for this?

Mr. HAUER. Well, I completely agree with you that the psychological component of preparation and response to any kind of a terror event is key, so much so—

Mr. KENNEDY. Then why didn't you mention it in your whole statement?

Mr. HAUER. Well, I don't know, but I don't have a good—

Mr. KENNEDY. That is troubling when you consider the statistics I just mentioned.

Mr. HAUER. Well, I also know the statistics quite well and—

Mr. KENNEDY. Well, then why didn't you mention it in your statement?

Mr. HAUER. Well, I can't give you an answer to that, but what I can give you an answer to is—

Mr. KENNEDY. We are talking about investing hundreds of millions of dollars protecting this public. You are coming before this

committee asking for money for BioShield, and you have no comment on the——

Mr. HAUER. No, no. I didn't say I didn't have a comment on this issue, I said I couldn't answer the question about why it wasn't in my testimony. Now, if you would let me answer, I will answer——

Mr. KENNEDY. I am happy to let you answer.

PSYCHOLOGICAL CONSEQUENCES OF TERRORISM

Mr. HAUER [continuing]. The issue about psychological consequences of terrorism, because we have been very aggressive about dealing with this issue, so much so that we are bringing some of the leading people on the psychology of terrorism into my office. Dr. Ann Norwood from the Department of Defense, who has been working with Bob Ersano who has published widely on this issue, is joining my staff on Monday. I have been trying to get Ann out of the Army and to come on board for some time now. We have held numerous conferences with the media and with the psychological community, with the psychiatric associations, to focus on the issue of this psychology of terrorism.

There are many components in looking at the psychology of terrorism, including how to manage the worried well and how to communicate with the worried well; how you deal with the overwhelming number of people who are not going to be sick, but who are going to demand therapy. All of that is part of a bifurcated approach involving both the psychology and the media of dealing with terrorist events. I have personally worked on this for many years, and it is one of the things that we have looked at as a key component of dealing with response to terrorism.

We have also established a benchmark within the HRSA guidance that requires State and local governments to have trained people to manage the psychological consequences for both adults and kids in both the pre- and post-terrorist event.

Mr. KENNEDY. Well, I appreciate you have been meeting with different folks. I don't pretend to think that you haven't thought about it. What I am asking specifically, what are you doing about it? And if you have a whole statement and you read it—and I might add it is one of the most extensive statements I have heard anyone read before any committee since being here—and it doesn't mention it at all, that causes some concern to me.

The fact that you just gave me an answer which says you have been meeting with folks and you think that it is a problem, but you haven't given me anything other than, stating that States are going to have somebody put in place to help us coordinate.

Mr. HAUER. No, I didn't say we have been meeting. We are working on it, and I would be happy to submit to you all the things that are going on in focusing on this issue, because this is an issue we have taken seriously. This is one the Secretary clearly has had as one of his priorities. It is one of the one——

Mr. KENNEDY. Well, can you give me anecdotally one little thing that you are doing in this area?

Mr. HAUER. On the psychological, yes.

Mr. KENNEDY. What are we doing?

Mr. HAUER. We are holding and developing training guidelines for State and local governments so that they understand as one of

the benchmarks how they do risk communications. The risk communications piece of managing a terrorist event is going to be one of the most critical components of managing a terrorist event, and the way you do risk communications has a significant psychological overlay. So when we deal with risk communications and the development of risk communications, we have the members of the psychological community on board, and that is one of the reasons Dr. Ann Norwood, instead of working with us on a part-time basis, will be coming on board on a full-time basis.

Mr. KENNEDY. Are you on the board of Homeland Security?

Mr. HAUER. No, I am not. Those are mostly folks from outside of government.

Mr. KENNEDY. But you must have an interest in making sure this component is part of the homeland security plan.

Mr. HAUER. We—at the State and local level?

Mr. KENNEDY. No. At the Tom Ridge level.

Mr. HAUER. Yes.

Mr. REGULA. Will you submit additional information for the record, because we need to move on.

[The information follows:]

MENTAL HEALTH COMPONENT

For the Bioterrorism Hospital Preparedness Program, HRSA is including Mental Health as a priority area in the program guidance for the FY 2003 round of cooperative agreements. Grantees will be requested to define which hospitals or outpatient centers will provide mental health services appropriate to the aftermath of a terrorist incident. They will also be asked to identify available behavioral staff who are trained in incident stress management. In addition, they will be asked to develop and disseminate mental health messages to the population affected by a terrorist attack.

Within the new Bioterrorism Training and Curriculum Development program, which begins in FY 2003, one focus is on the provision of continuing education and training for practicing providers. The applicants must demonstrate the ability to provide training to a comprehensive range of health care professionals in an entire state, in a region of the state, or in a multi-state region either through their own efforts or through partnerships. The targeted trainees this program is designed to address include both hospital and community-based health care providers. Mental health providers will be one of the targeted health professions.

Mr. REGULA. Mr. Sherwood.

Mr. SHERWOOD. Thank you, Mr. Chairman, and I commend each of you for your efforts to protect the American public health, and we know the world is a nasty place, but I think we will find, as we have to rise to the occasion, that the American public will suck it up and perform admirably.

What I am concerned about, that you will commingle funds for bioterrorism with the threats that Mother Nature throws at us—like your testimony this morning mentioned SARS several times—and if we do that, we may not be sufficiently prepared to respond to very real bioterrorism threats. It is essential that our bioterrorism projects be managed, I think, as a separate and identifiable program so that we can track the funds and the research results.

Is there a separate budget and distinct account for bioterrorism projects, or are the bioterrorism funds handled in the same way as other public health research funds?

MONITORING AWARDED FUNDS

Mr. HAUER. No. They are—we have separate accounts for tracking the bioterrorism funds. The money is sent to the States and the cities through separate accounts. They are not commingled. One of the things that we wanted to ensure and one of the Secretary's goals was to ensure that we showed measurable gains in our country's preparedness for dealing with the health and medical consequences of bioterrorism.

So as we have sent the money out, not only do the States and cities have to meet the benchmarks, but we have a 3-tiered system of oversight that allows us to monitor and assess what they have done, whether they have met the time frames that they said that they would meet and to ensure, quite candidly, that the money is not being used to substitute for other kinds of public health programs.

Now, having said that, there are going to be benefits from building bioterrorism preparedness at the local level:

As we build and rebuild the public health structure and infrastructure to better prepare for bioterrorism, it will obviously have a significant impact in better preparing States to deal with any kind of emerging infectious disease.

As we prepare hospitals to deal with the chemical and biological patients, they will be better prepared to deal with mass casualty incidents.

So I think there are secondary benefits, but the money that goes out is going through a separate pipe, so to speak.

Mr. SHERWOOD. I agree with you 100 percent that there is serendipity here; that if we are prepared for one, we will be prepared for the other. But I am on the Homeland Security Appropriations Committee, and it is so important now that we focus a substantial amount of our resources in that regard, and in all the things we do in homeland security, it is so easy for the money to get sucked up in general operations.

Do you have one person, sort of like a bioterrorism czar, that is ultimately responsible for all bioterrorism research at HHS so that we can ensure that that is focused and accountable for the overall results?

Mr. HAUER. Well, the R&D, the research, falls under NIH, and they work collaboratively with CDC and with DOD to look at how we can be more efficient in all of our needs, both for the military and the civilian side. Elias.

Dr. ZERHOUNI. Yes. Actually we do have—the direct answer to your question is there a single person with a budget and the overall oversight for programs at CDC. At NIH, the answer is no. However, the mechanisms that we have put in place in terms of what you just heard about, interagency coordination, we have a strategic plan development process which is between Secretary Hauer, Dr. Gerberding and Dr. Fauci. At NIH we have a Trans-NIH Bio-defense Committee which is chaired by Dr. Fauci that involves all of the institutes in all aspects of the biodefense response, including, Congressman Kennedy—I agree with you—psychological biodefense. Dr. Tom Insel, who is the head of the NIMH, is actually

doing a lot of research, not just in posttraumatic stress disorder but what we call pretraumatic stress disorder.

Mr. KENNEDY. And SAMHSA is not getting a nickel in this budget for bioterrorism response and they are the lead mental health agency.

Dr. ZERHOUNI. To answer, Congressman Sherwood, the answer is we do not have a czar, but we certainly have the Secretary of HHS leading a very small group. I participate, Dr. Fauci participates. All of us participate. And all of the budgets for biodefense are looked at as one item in the interactions between the Department, CDC, inside the Department in OMB.

Mr. SHERWOOD. And in these discussions and meetings, do you have a representative from the Department of Homeland Security?

Dr. ZERHOUNI. The Department of Homeland Security, we have worked extensively with them during the preformation. There is an Under Secretary for Science and Technology, and we have a memorandum of understanding with the Department, whereby that person will be the key coordinator with all of HHS's activities.

Mr. SHERWOOD. If you study the world a little bit today, it appears that it is not if we are going to have to respond to bioterrorism but when. And I know that your research is impeccable, but I am concerned about the ability to get it down to the first responders.

Mr. REGULA. Dr. Weldon.

Mr. WELDON. Thank you, Mr. Chairman.

Secretary Hauer, about a year ago I saw an article published in Science which was funded by the Federal Government through DARPA on how to use off-the-shelf products to synthesize polio virus. And you are funding a lot of research, NIH is funding a lot of research. I would imagine that some of this research is providing information that we may actually not want published. When you issue these research grants, do you sign any restrictions with the researchers, and is that an issue? Because I know in academic research, it is publish or perish; and so how do you get quality researchers to do research that you cannot allow them to publish?

Mr. HAUER. There was a very lively debate about that article you are talking about. I remember it well. And I will ask Dr. Zerhouni to address the—

Dr. ZERHOUNI. Dr. Fauci really has worked on this issue.

PUBLISHING RESEARCH PAPERS

Mr. WELDON. I would love to hear what you have to say, Dr. Fauci. Great to see you again, by the way; and all of you, you have been here a lot lately.

Dr. FAUCI. Indeed. You bring up a very good point. That article regarding the synthesis of the polio vaccine—excuse me, the polio virus—from scratch really galvanized, I think, a lot of productive discussion at the NIH, at the CDC, and among the academic community. The general feeling is that when you think in terms of basic research in microbiology, that transparency and openness the way this situation was is the right way to go. But we need to—and we are working through the National Academy of Sciences as well as the editors of the top journals, the scientific journals—Nature, Science, PNAS, et cetera—to create what we call a more height-

ened culture of responsibility so that people actually think about what the ultimate implications for a particular experiment are.

Thus far on close examination with the National Academy of Sciences' appointed committee, this particular paper and related-type research was looked at very carefully, and it was felt that it is likely that this research probably would have gone on anyway, because the amount of knowledge that was gained for people to be able to do countermeasures far outstrips the difficulty that would occur of an individual getting ahold of that information and using it against us.

So your point is well taken. We need to heighten our degree of responsibility, but thus far we don't see any reason to restrict or classify research, at least as it occurs at the level of the National Institutes of Health.

With regard to the publication, they have now formed again, under the auspices of a group of journal editors, a committee that, at least when reviewers or journals flag something that looks like it might possibly have something that need not be fully published, it would then go to that committee to be examined and a group of people would make a determination about it.

Mr. WELDON. Well, thank you very much. I am very pleased to hear that the academic community and the research community and people at NIH are taking this issue very seriously. I would love to get into this more with you, but I think I only have a minute and a half left, and I have to go to another hearing.

Thank you, Mr. Chairman. I yield back.

Mr. REGULA. Thank you. We are going to have another round of questions. I have a couple, but first I would yield to Mr. Wicker for a brief question.

SEVERE ACUTE RESPIRATORY SYNDROME

Mr. WICKER. Thank you, Mr. Chairman.

Dr. Gerberding, I want to ask you about SARS. You mentioned it a couple of times in your testimony. In your opinion, is there a way for a terrorist or an evil-doer to use the SARS virus against the American public?

Dr. GERBERDING. I think there is a way to use the SARS virus, because it is a contagious virus and it spreads very quickly. It would not be a very likely choice of a terrorism agent because it does not have a very high lethality compared to something like smallpox or botulism or anthrax. And certainly when it emerged, we kept a very open mind about the possibility that it was intentional and not a naturally acquired situation. All of the information we have right now suggests it is in fact a naturally emerging problem.

But, you know, any infectious disease that is transmitted efficiently in a population and causes disease and concern is conceivably an agent of terrorism, and when you look at already the economic consequences from SARS, that is a part of terrorism as well.

Mr. WICKER. Indeed it is.

Dr. GERBERDING. It does have many of the criteria that would qualify as a potential threat.

Mr. WICKER. How many people have contracted SARS? How many people have died of SARS? And how are we going to in a

global economy, in a situation where there is so much travel by air as well as boat and whatever, how are we going to keep it out of the United States?

Dr. GERBERDING. This is a big challenge. I don't have today's SARS figures because I just flew in on the red-eye but as of yesterday, there were approximately 2,600 cases of SARS in the world, and globally WHO is reporting 89 deaths yesterday.

I suspect that that still represents underreporting, because we are not getting complete information out of China, although we are getting much more information this week than we had in the earlier stages of the outbreak.

Containment right now does not rely on a vaccine, because it will take us at least a year to have something along those lines. We don't have a treatment for this, so containment really resides on, number one, detecting everybody who has it and isolating them so they don't spread it; and secondly, alerting clinicians, alerting travelers, alerting household contacts, to the kinds of things they need to do to protect themselves from acquiring it if they are in contact.

In places where we have the advantage of recognizing a case early and using those precautions, we do seem to have success with containment. In the United States, for example, where yesterday we had 148 cases, 5 of them involved household contacts; 3 of them involved healthcare workers. But that is a very low spread to the household contacts and healthcare workers compared to the situation in Hanoi, for example, where 1 patient was the source of infection in 56 percent of the healthcare workers that they had any contact with in the hospital where they weren't using these containment procedures. Containment under the best circumstances does seem to work.

But you brought up the very important point that primarily this is a disease being spread by travelers and in close communities, and global travel is the reason why we have cases in so many countries everywhere in the world. Things that might help the containment beyond just identification and isolation include seasonality. Most respiratory viruses come and go. They are the strongest in the winter seasons. They die back in the summer. So that can help in a given area to buy some time so that we will be able to anticipate next year's cycle and respond more quickly. And the problem with that, of course, is that what is winter here is summer in the southern hemisphere and vice versa, so as this emerges in the southern hemisphere, that is not going to help it from the global perspective.

Bottom line, this is a big challenge. We don't know where it is going. It is very early. We are very encouraged about how quickly CDC and the other scientists have been able to find the virus and identify tests for infection and so forth, but we have got a long way to go to understand where it is going to spread and what we need to do about it.

Mr. WICKER. Thank you.

Mr. REGULA. Mrs. Northup.

Mrs. NORTHUP. Thank you. I wondered about the coordination between the health community and the Intelligence Community. As I listen to you all itemize the different challenges that we face, both biologically and chemically, it occurs to me that there might

be some that emerge that I assume the security—the Intelligence Community would be the first to know about, and I wondered how close the relationship is there.

Dr. GERBERDING. I can start from a CDC perspective, because I want to say something very positive about Secretary Hauer and the Department, in that they have put a strong emphasis on being an integrative point for intelligence from the various agencies that have intelligence and then very quickly turning that around to the public health community so that we can distribute it to our partners. But also at CDC in the last year we have created positions for FBI agents. We have an active FBI agent on site at CDC. We have an FBI analyst who reads all of the intelligence coming in every morning and turns it around into a report that I can understand.

As Secretary Hauer said, we are getting security clearance for health officers in States so that we can share classified information with them before it is available for common distribution in the press and so forth.

It is a challenge to take what has been a very open culture of academia and healthcare and add this additional element into it to be equipped to deal with the intelligence information. And we are evolving very quickly to manage it, but I think we have got the infrastructure and the access to that information now more than we ever had before.

And I will just add that we have a CDC employee who is on detail to the FBI in Washington, and we are doing joint training with the FBI and public health officials around the country to learn how to investigate together, learn each other's culture, and go through actual scenarios of practicing how we would share information, what we can share, what we can't share, and how to protect the chain of evidence and still protect human lives.

Mrs. NORTHUP. As my constituents pick up the paper, turn on the television, they are most likely confronted with challenges that they have never worried about. They have certainly heard about smallpox, because historically smallpox was a challenge, but certainly they haven't in their lifetime worried about having it.

But then there are new names, like ricin and things that we find out are in a London apartment, that no one has ever gone to sleep thinking about that might be a challenge to their health. And sometimes that could create the impression that maybe there are 1,000 more things that are actually threatening their good health that they don't even know about.

What sort of level of reassurance can we give constituents, our constituents, about the challenges of bioterrorism, chemicals and biological agents, in terms of just—do we have a good catalog of what challenges us, and do we have a pretty good and sophisticated system for addressing those challenging—and is that reassuring, or should it terrify them?

Mr. HAUER. I think there has been—first, let me follow on to Julie's point about our communications with the Intelligence Community. I will be very brief about this. Every morning the Secretary and I get briefed by somebody from the CIA who does the same briefing for us that the President gets every morning. If I see anything in the briefing that is of significance that really is emerg-

ing quickly, I will call Dr. Gerberding right away to let her know. But my staff every morning does a secure videoconference with the CDC staff at 10:00 a.m., because we have a 7:00 a.m. secure videoconference with the whole Intelligence Community that is run by a member of my staff.

I now have 2 people on staff who are detailed from the CIA. One of them is a fairly senior level who is a rep from the DCI, and I have also brought on board a retired FBI agent who ran the FBI's counterterrorism unit, Bob Blitzer. So we have developed very good linkages with both the Intelligence Community and with the law enforcement community.

As far as your concerns about the agents, one of the things that we continue to do from both an intelligence focus and in looking just broadly at the types of things that are available to the public is try and assess what chemical, biological, and radiological agents pose the greatest threat, and we have basically a matrix that has been developed of chemical agents and biological agents.

I know one of the things that NIH is doing is trying to look at what the countermeasures are, because there are, particularly for chemicals, a number of them that we simply don't have antidotes to. There is cyanide and the organophosphates. Sarin and VX are 2 we do have antidotes for. But things like Phosgene, methylisocyanate, and some of the other really bad chemicals that are available out in the general community that are manufactured throughout the country are things we are continuing to get information out as we see concerns about them.

CDC, after the discovery of ricin in London, had information on their Web site within about 24 hours so that the medical community, as they got questions, had a resource to go to to focus on ricin.

But we have got a pretty good sense of what the threat agents are, what we need to be prepared for. And one of the beauties of BioShield is that BioShield will rapidly allow us to take some of the threat agents that we don't have countermeasures for and put money into development on R&D right away to try and develop countermeasures for them.

Mrs. NORTHUP. Thank you.

Mr. REGULA. Mrs. Lowey.

Mrs. LOWEY. Thank you, Mr. Chairman. And as a segue to my question, with great respect for my colleagues, I just wanted to respond to your comment to Mr. Sherwood. My feeling is that the epidemiologists, the nurses, the physicians, the labs, all the procedures that are in place should get every dollar they need. And I know it is very difficult to distinguish the work that has to be done to deal with an outbreak of flu, an outbreak of SARS, whether it is going into the bioterrorism account or another account. So from this member's point of view, I want to know exactly what you need to function at the top level, whether it is keeping us safe from flu or HIV or a bioterrorism attack or anything else, and I personally appreciate everything you are doing and I want to know exactly what you need.

Which leads me to my question about hospitals. And I guess I should direct it to Dr. Duke. We all know that hospitals are a key component in our first responder system, and in the midst of preparing for a nuclear, biological, or chemical attack. However, I am

very concerned that their efforts will really be stunted by the administration's budget.

A couple of numbers, as you all know but to repeat for the record. Today the Federal Government has obligated \$643,000,000 to hospitals for bioterrorism preparedness activities, of which only \$125,000,000 has been released. To put this in perspective, of the \$125,000,000 provided in fiscal year 2002, hospitals outside of New York City, with the exception of regional resource centers, have received \$10,000 apiece.

Although we don't know yet how the \$518,000,000 in fiscal year 2003 will be divvied up, if the money is distributed according to the fiscal year 2002 formula, the State will receive \$18,000,000.

New York State's hospitals have already spent almost \$500,000,000 on bioterrorism preparedness, and I would guess the States have experienced the same phenomenon. They have identified more than \$1,000,000,000 in additional needs, and I don't say we should continue to be a cash cow, but I want to be sure we are responsive to their needs.

Now, the 2004 budget provides another \$518,000,000 for hospital preparedness, but in my judgment, in talking to professionals in my State, that is not enough. The hospitals need, you know, show-ers, decontamination units, extra beds, better trained staff. They need isolation rooms, robust computer systems, the ability to detect atypical disease outbreaks.

Yet we are asking hospitals to take on greater responsibilities. The Federal Government is reducing Medicare payments and not adequately helping hospitals cover the rising costs of caring for the uninsured.

So this is why I think this is also interconnected and we have to be real. We can't pretend that we have 3 separate columns here. Is the administration currently looking at the larger issues that are facing our hospitals as it asks them to take on greater responsibility? How can hospitals be a key player in our first responder team without the additional funding that they truly need?

Dr. DUKE. Obviously we are very concerned about the health of our hospitals, and you are accurate, and those statistics are pretty—are quite current, that it is a rather slow pattern of outlay of the funds. But there are some sensible reasons for that, that I think you will see a much more rapid outlay of those funds. When you start a new program, one of the first things you do is an assessment: What do you need to fix, and what does it take to fix it? And so we have had a concentration on that kind of planning. I think States, like the Federal Government, have somewhat convoluted processes for getting things like procurements done and personnel hired, and we all as bureaucrats recognize that those sometimes can slow things down.

So one of the things I think that is most encouraging is that we are now seeing the hiring of people and the retention of some really outstanding people in the States carrying out these responsibilities and that the procurement processes are now moving ahead. So I think you are going to see a much more rapid outlay.

And also the emphasis in the second year is more on getting those plans implemented, and we have made a tremendous effort to do that. Specifically, we have actually asked the States to come

in and ask for part of their 2003 money in advance of the actual grant process. We put a note out last week from the Secretary to the Governors, making it clear that we would release up to 20 percent of the 2003 money now to help with a variety of problems—vaccination for smallpox, retention of personnel that they have hired that they might need some help in keeping until they get their 2003 money in August, acceleration of their programs. So we have actually tried to meet some of the immediate needs and we have done that on an expedited basis. They don't have to do a big fancy approach. They just need to come in with a very short-form budget that says this is what we need, and we stand ready to get that out and we will do that within 3 weeks.

HOSPITAL SURGE CAPACITY

Mr. HAUER. Let me also add that a couple of the things that we are trying to approach in the grant process is when you talk about surge capacity, which is an absolutely critical issue, surge capacity involves 3 components: beds, personnel, and equipment. And what we are trying to do and one of the things that we have done through the grant process is focused on a regional approach. Not every hospital needs a decon shower, but if you focus on a regional approach, resources can be shared and moved around.

In New York City in the years I spent there as the commissioner, we didn't put or think of having decon showers in every hospital, didn't see the need for it, because you are going to want some hospitals that you don't bring contaminated patients to. You are going to want to have—you know, we are going to have 3,000 EMS calls a day, despite the fact that you have a regular chemical—or a chemical terrorist incident. So you have got to maintain your healthcare capacity even though you have had a terrorist incident.

So this regional approach has been very key and underpins a lot of what we are trying to do at the local level, trying to focus on what equipment to buy, on how to develop surge capacity. For this next round of grants we are increasing surge capacity to handle actually ill patients from 500 patients to 500 per million population, whichever is greater.

And, finally, the issue of the \$10,000 for hospitals is not ours. What has happened is the States have determined how that initial grant money went out to their hospitals. We did not dictate. Again, we tried to let the States have a lot of flexibility.

One of the things we are going to be looking at in this next round of grants is we are going to ensure that we certainly understand that the States had to buy a lot of infrastructure and laboratory capacity and information technology with the first round; but the second round, a lot of that has already been purchased. So a lot more money should be flowing out to both city and county health departments, and a lot of the hospitals should be seeing it, and we will be monitoring that as part of our process.

Mrs. LOWEY. Thank you for your generosity. Thank you very much.

Mr. REGULA. Yes. One thing I want to come back to with all of you is accountability, because we are going to put a lot of money out there, and we want to have some assurance that we are getting results. But I will wait until we finish the questioning.

Mr. Sherwood.

HOMELAND SECURITY ACT

Mr. SHERWOOD. Thank you, Mr. Chairman.

I would like to return to the homeland security part of this discussion, and if you will forgive me, the Homeland Security Act requires that the Department of Homeland Security develop in consultation with other appropriate executive agencies a national and strategic plan for identifying priorities, goals, objectives and policies for and coordinating the Federal Government civilian efforts to identify and develop countermeasures to chemical, biological, radiological, nuclear and other emerging terrorist threats, including definable goals, measurable objectives.

I am still concerned that the Department of Homeland Security is not a part of your bioterror planning committee and I—

Mr. HAUER. Our bioterrorism planning—

Mr. SHERWOOD. Yes.

Mr. HAUER. Well, Mike Byrne sits in on pretty much all of our meetings. This afternoon I will be spending 2 hours at the White House with the Homeland Security folks, with DOD, and our folks in the VA. We bring Homeland Security in on pretty much all the issues that we feel they need to be part of.

The R&D piece is still being worked out. How Dr. McCrery's shop and Parni Albright's shop is going to interact with our research folks is one that is evolving, because there is a checkoff that has to be done by the Department of Homeland Security. But as far as planning, I feel very comfortable that they have been very involved in our plans and sit in—you know, we have them sit in on many of our meetings. They certainly have been welcome to sit in on all. But all the plans we have put together from smallpox to botulinum, they have been in the planning meetings. We had a whole series of botulinum planning meetings, and Homeland Security sat in on, I think, pretty much every one of them.

Mr. SHERWOOD. Thank you.

Mr. Chairman, for the record, could we ask them to provide a list of all the bioterrorism projects being funded in 2003 and 2004, including a brief description of the research, the name and affiliation of the researcher, and the schedule for completion of the work product?

Thank you very much.

Mr. HAUER. I would be happy to provide that.

Mr. REGULA. Thank you.

[The information follows:]

CDC RESEARCH PROJECTS ON BIOTERRORISM

NCID's Office of Extramural Research

In FY 2003 the Office of Extramural Research will fund investigator-initiated research grants (R01 and R21 mechanisms) for research in biodefense and emerging infectious diseases. Eligible applicants include for-profit or non-profit organizations, public or private institutions, and other eligible applicants. Applications received in response to the announcement will be peer reviewed for scientific merit by the NIH Center for Scientific Review in July 2003. The selection of proposals recommended for funding will be made in August by a CDC secondary review committee.

In FY 2004, the OER will fund new starts in research in biodefense and emerging infectious diseases. Final funding decisions won't be made until well into FY 2004.

Anthrax Vaccine Research Program (AVRP)

AVRP Human Clinical Trial Sites:

- Mayo Vaccine Center - Dr. Greg Poland
- Baylor College of Medicine - Dr. Wendy Keitel
- Walter Reed Army Institute of Research - Dr. Janiine Babcock
- University of Alabama at Birmingham - Dr. Mark Mulligan
- Emory Vaccine Center - Dr. Harry Keyserling

Description of the Research:

We initiated a human clinical trial of Anthrax Vaccine Adsorbed (BioThrax or AVA, BioPort Corp) to assess route change and dose reduction:

- o To date, 5 sites have enrolled 1223/1560 (78%) of total volunteers, we expect full enrollment by July 2003
- o Interim analysis will be presented to FDA Sept 04 - Goal is to drop Dose 2 and change to intramuscular route of administration
- o Final analysis will be presented to FDA Apr 07 - Goal is to drop additional doses from primary regimen and reduce frequency of boosters

Non-human Primate Study:

- Battelle Memorial Institute - Dr. Jim Estep
- Emory Vaccine Center - Dr. Denyse Levesque

Description of the Research:

We developed non-human primate (NHP) studies to determine correlates of protection against inhalational anthrax and to support the objective of dose reduction in human clinical trial:

- o Animals vaccinated by similar regimens as in human study, challenged at 12, 30 and 42 months post vaccination with 200LD50 *B. anthracis* Ames strain equivalents
- o NHP challenge experiments began in March 2002; final data expected by FY05

Correlates of Protection Study:

Emory Vaccine Center - Dr. Robert Mittler

Battelle Memorial Institute - Dr. Carol Sabourin

Description of the Research:

- o We developed serologic assays to assess human and animal immune response to anthrax vaccine. The specimens are obtained from the studies described above. Data from this study, expected at interim analysis in Sept 04 and final analysis in Sept 07 will determine whether a person is protected by AVA, when protection is achieved and its duration.

The AVRП studies have been endorsed by Institute of Medicine Committee for CDC Anthrax Vaccine Safety and Efficacy Plan in its October 15th 2002 Report. The benefits of this research extend to the military and civilian community:

- o Human clinical trial will help optimize the use of the current vaccine, reduce side effects, and increase its acceptability among vaccine recipients
- o Studies will provide understanding about correlates of protection that will extend to the second generation anthrax vaccines

Improved Environmental Sampling Methods for Bioterrorism Response**Investigation**

The objective of this program is to expand our capacity to employ environmental sampling methods in bioterrorism emergency response investigations. Various techniques including surface sampling (i.e., wipe, swab, and vacuum), air sampling (i.e., culturable and non-culturable), and bulk sampling for bioterrorism agents will be evaluated. These comparisons will be completed using surrogate agents in chamber-based studies in cooperation with established BT research facilities. Analytical services will be provided by an accredited laboratory with significant microbiological expertise. Chamber studies allow application of known particle density to a variety of surfaces (and in the air) so that sampling methodologies can be evaluated for sensitivity, specificity, and recovery efficiencies can be determined for each phase of the process.

Bio-aerosol research

(Anticipated) In late FY 2002, NIOSH received funds to conduct research to improve CDC's preparedness for response to bioterrorist attacks. Building on the experience gained through response-activities related to the criminal release of anthrax spores into the US Postal System, and the subsequent contamination of buildings, expert panels were assembled to help identify critical topics for public health research. Two prominent topics for research were identified as quantitatively identifying the fate of microbial particles in buildings through aerosol dispersion testing and modeling, and understanding the risk of re-aerosolization and subsequent disease from particles on that have been deposited on surfaces within buildings. This project will fill critical gaps in knowledge in these two areas.

BT-Emergency Responder Respirator/Personal Protection

This project fulfills mandated NIOSH responsibilities through the testing and qualification of CBRN respirators to NIOSH approval requirements; product and manufacturing site quality audits; and enhancements to the NIOSH respirator certification programs and laboratories. Related activities include respirator certification, quality assurance audits, health hazard evaluations, providing technical assistance, enhancing laboratory capabilities and qualifications, and coordinating support services among federal and private sector organizations to achieve these objectives. Additionally, this project supports counter-terrorism and national preparedness by expeditiously incorporating technological advancements into national consensus standards.

BT-Standards Development for Respiratory Protection Equipment

Unlike industrial environments where hazards are characterized and controlled and respirators appropriately selected or battlefield conditions where respirators are designed to perform at defined threat levels, hazards at a terrorist event are normally unknown and uncontrolled. Hazards at a terrorist event, limited only by the imagination of the terrorist, include chemical, biological, radiological and nuclear toxic materials disseminated by explosion, aerosol spray, liquid spill, or evaporation. Respirators currently used by responders are not designed or tested to the extreme conditions possible at a terrorist event.

National Immunization Program Studies

- Anthrax Vaccine Absorbed (AVA) study at the Mayo Clinic to address human reactogenicity and immunogenicity trial for changes in route of administration and doses
- Anthrax Long Term Follow-up Study with GSA/Westat
- Study late onset effects from anthrax vaccination
- Clinical Immunization Safety Assessment (CISA) to fund 2 research studies
- Project for vaccine safety with Northern California Kaiser (NCK)

PLANNED FY 2003 AND FY 2004 BIODEFENSE INITIATIVES

Due to the recent increased emphasis on biodefense research, the NIAID has developed initiatives to meet short-, intermediate-, and long-term goals contained in the NIH Strategic Plan for Biodefense Research and the Research Agenda for Category A, B, and C agents as defined by the CDC. The Strategic Plan and Research Agenda stress two over-arching and complementary components: basic research into agents with bioterrorism potential and the specific and non-specific host defense mechanisms against those agents; and applied research with pre-determined milestones for the development of new or improved diagnostics, vaccines, and therapies.

The following is a list of planned initiatives for fiscal years 2003 and 2004. Most of the FY 2003 projects are currently in the review cycle with plans to fund successful applicants this summer.

Planned FY 2003 Initiatives

- **Unsolicited Investigator-Initiated Research**
 - Investigator-initiated research has and will continue to be the foundation of research at NIAID.
- **Cooperative Centers for Translational Research On Human Immunology and Biodefense**
 - The long-term goal of this program is the translation of research using animal models of immunity to infection into clinical applications in humans. The immediate purpose is to support stable, flexible, centralized infrastructure and research needed to promote and coordinate multidisciplinary basic and clinical research in human immunology as it relates to defense against agents of bioterrorism and emerging/re-emerging infectious diseases.
- **Innate Receptor and Adjuvant Discovery**
 - The focus of this initiative is to expand opportunities to discover and characterize new adjuvant candidates based upon immunological principles to enhance the potency, longevity, and safety of specific vaccines for biodefense, and to enhance nonspecific immunity for immediate protection against acute infectious threats.
- **Cooperative Research for the Development of Vaccines, Adjuvants, Therapeutics, Immunotherapeutics, and Diagnostics for Biodefense**
 - The objective of this project is to stimulate original, novel, and innovative research of sound scientific rationale, requiring comprehensive team and multidisciplinary effort that is likely to result in the progression of promising vaccines through the product development pathway.
- **Basic and Clinical Approaches to Controlling Human Respiratory Pathogens**
 - This project supports pre-clinical and clinical research activities on emerging and re-emerging bacterial and viral respiratory pathogens; integration of human mucosal immunity with clinical research; and product development.

- Production and Testing of Vaccines Against Anthrax
 - This initiative supports the development and production of rPA vaccines against anthrax. This includes moving the vaccine candidates through several stages of development, including manufacturing pilot lots of the vaccine candidates, testing for safety in laboratory and clinical trials, testing for efficacy in animals, and preparing and submitting all necessary Food and Drug Administration (FDA) applications.
- Smallpox Modified Vaccinia Ankara (MVA) Vaccine Research
 - A leading candidate for a 3rd generation vaccine is MVA. MVA stimulates protective immune responses against vaccinia in animal model studies and has been shown to be immunogenic in humans. This program will support the development, manufacture and conduct safety trials of MVA vaccine candidates.
- Biodefense and Emerging Infections Research Resources Program
 - This objective of this program is to provide unique, quality assured biodefense-related reagents and resources to the scientific community, facilitating: 1) the understanding of the pathogenesis of Category A, B & C priority pathogens and emerging infectious disease organisms; and 2) the development and evaluation of vaccines, therapeutics and diagnostics for these organisms.
- Network for Large-Scale Sequencing of Microbial Genomes
 - This network will establish a state-of-the-art high throughput DNA sequencing centers that can sequence genomes of microbes and invertebrate vectors of disease.
- Regional Biocontainment Laboratories (RBL)
 - The overall planned objective of the RBL construction program is to provide funding to design, build, renovate, certify and install fixed equipment into state-of-the-art BSL-3 biocontainment laboratories and the necessary associated animal facilities, and research support space.
- Regional Centers of Excellence (RCE) for Biodefense and Emerging Infectious Diseases Research
 - RCEs are planned as large, multidisciplinary regional resources for the scientific community, which will provide the scientific information and translational research capacity to make the next generation of therapeutics, vaccines and diagnostics against Category A-C Agents, with particular emphasis on Category A.
- Construction Quality Management Support Services
 - This service is responsible for management oversight of all RBL and National Biocontainment Laboratory construction projects.
- Biodefense Proteomics Research Programs
 - This initiative's primary goal is to characterize the pathogen and/or host cell proteome, identifying proteins associated with the biology of the microbes, mechanisms of microbial pathogenesis, innate and adaptive immune responses to

infectious agents, and/or non-immune mediated host responses that contribute to microbial pathogenesis. It is anticipated that the research programs will discover targets for potential candidates for the next generation of vaccines, therapeutics and diagnostics using existing proteomics technologies, augmentation of existing technologies, and/or the creation of novel proteomics approaches and performing early stage validation of these targets. This initiative is an integral part of NIAID's program in Biodefense to address the Nation's biodefense needs.

- **Resources for Biodefense Proteomic Centers**
 - The Administrative Centers will design, develop, and maintain a publicly accessible web site, monitor and facilitate the deposition of reagents and protein targets generated by the Proteomic Research sites, establish a Scientific Advisory Committee and organize programmatic meetings and related activities.
- **Respiratory Pathogens Reference Laboratory**
 - The focus of this laboratory will be the development of reagents and biological assays for bacterial and viral respiratory pathogens. The Respiratory Pathogens Research Reference Laboratory will be part of a coordinated, interactive, multi-disciplinary network to help support the development of vaccines and drugs against respiratory pathogens, including those that present concerns for bio-defense and/or emerging infections.
- **Microbial Genome Sequencing Centers**
 - The initiative addresses the need for additional sequencing of microorganisms and invertebrate vectors of disease. This includes the carefully selection of species, strains, and clinical isolates, nearest neighbors and generate genomic data for different uses such as forensic/strain identification and targets for diagnostics, vaccines, and antimicrobials/drug development.
- **Food and Waterborne Diseases Integrated Research Network**
 - The Network's research focus is to elucidate fundamental mechanisms of host defense in the gastrointestinal tract against food or water-borne enteric pathogens or toxins.
- **Immune Epitope Database and Analysis Program**
 - This initiative will focus on two major areas in support of biodefense research: 1) design, develop, populate, and maintain a publicly accessible, comprehensive immune epitome database; and 2) provide tools to help researchers access information in the database.
- **Biodefense and Emerging Infectious Diseases Research Opportunities**
 - This initiative addresses the need for more basic and applied research on Category A, B, and C pathogens, their toxic products, and the body's immune defenses against them.

- **Hyperaccelerated Award Mechanism in Immunomodulation Trials**
 - This program will use patient samples for the evaluation of immunologic and other relevant parameters to facilitate the study and definition of immunological mechanisms underlying the intervention, the mechanisms of disease pathogenesis, surrogate/biomarkers, markers of disease activity and therapeutic effect, and mechanisms of human immunologic function.
- **Biodefense Partnership Awards**
 - The goal of this initiative is to facilitate collaborative partnerships between government, academia, and the private sector to develop novel biodefense products.
- **Master Contract for Preclinical Development**
 - Provides overall project management to establish and meet the preclinical product development time lines. This includes: process development and production, safety testing, regulatory documentation, and information technology and data management for vaccines and non-vaccine prevention modalities, and research-grade products suitable for early phase human clinical trials.
- ***In Vitro* and Animal Models for Emerging Infectious Diseases and Biodefense**
 - This project will provide a range of developmental resources for testing of new therapies and vaccines (e.g. targeted screening, animal models, and non-human primate models) against emerging infectious diseases including bioterrorism pathogens.
- ***In Vitro* Antiviral Screening**
 - This initiative provides screening systems for the assessment of the efficacy of potential antivirals for bioterrorism agents.
- **Humanized Monoclonal Antibody Production Facility**
 - This initiative is designed to establish an antibody production facility that will produce fully-human monoclonal antibodies and/or polyclonal antibodies or single chain variable fragments.
- **Clinical Trials Management**
 - This resource provides clinical site assessment, clinical trial preparation, training, quality assurance, and pharmacovigilance/safety monitoring of biodefense clinical trials.

Planned FY 2004 Initiatives

- Ongoing support for FY 2003 and prior initiatives
- **Bioinformatics Resource Center**
 - This initiative is designed to: develop and maintain comprehensive, relational databases to collect, store, display, annotate, query, and analyze genomic, functional genomic, structural and related data for microorganisms responsible for emerging and re-emerging infectious diseases including those considered agents of

bioterrorism. Both single organism databases, as well as multi-organisms databases, especially in the area of agents of bioterrorism, will be sought. This will be done in order to provide the research community with a research resource for access to a large amount of genomic and related data with the long-term goal of identifying putative targets for the development of drugs, therapeutics and diagnostics.

- **Identifying Targets for Therapeutic Interventions Using Proteomic Technology**
 - Under this initiative, highly interactive, multi-disciplinary teams with expertise in biochemistry, biological sciences, physics, engineering, genomics and proteomic technology, bioinformatics and statistics, clinical sciences and drug discovery will be formed to augment and/or develop innovative proteomics approaches for application to therapeutic strategies for microorganisms considered agents of bioterrorism. Areas of proteomics research include: protein profiling for examining patterns of differential expression to identify diagnostic biosignatures and putative protein candidates for targets; and the development and application of innovative proteomic technologies to the study of specific cellular process, functional pathways and networks, protein-protein interactions, and novel post-translational modifications.
- **Large Scale B&T Cell Epitope Discovery Program**
 - This program will consist of: 1) identification of linear and conformational B cell epitopes; 2) identification of T cell epitopes that bind class I, class II, and non-classical MHC molecules; 3) definition of peptide binding motifs on a sufficient number of HLA alleles to cover the human population worldwide; and 4) design and development of novel or improved high throughput screening assays for B cell and/or T cell epitope discovery that are easily transferable to the broader scientific community, thus providing standardized methods to facilitate more rapid discovery.
- **Population Genetics Analysis Program**
 - This program is designed to characterize polymorphisms in human immune response genes, including the expression patterns of innate and adaptive immune response genes after natural infections with, or vaccination against pathogens, and to examine the functional significance of these responses. These studies will provide a better understanding of immune responses to infection and vaccination, which may lead to identification of novel immunotherapeutic targets for vaccines and drugs to prevent and treat infections.
- **Novel Therapeutic Strategies for Botulinum Toxin**
 - Botulism can result from ingestion or inhalation of one of seven different serotypes of neurotoxin produced by *Clostridium botulinum*. This initiative will support development of products to neutralize these toxins. Strategies may include, but are not limited to, monoclonal or polyclonal antibodies. Work aimed at demonstration of protective efficacy in a mouse model will be a requirement.

- Reagent Development for Monitoring Immunity in Non-Human Primates
 - This initiative is designed to accelerate research in non-human primate (NHP) models of allogeneic organ and tissue transplantation and other immunological stimuli by developing: 1) reagents for monitoring the immunity in NHPs undergoing graft rejection or other antigenic stimuli, such as vaccines; and 2) technologies for rapid typing of the major histocompatibility complex (MHC) genes to better match organ donors and recipients; improve understanding of the immune response to mismatched organs and tissues; and improve knowledge of the MHC alleles in various NHP species to accelerate vaccine research and development.
- Tools for Detection of Adventitious Agents in Cell Cultures
 - Research supported under this initiative would include: 1) identification of cellular markers/patterns that indicate that a cell line has progressed beyond an acceptable passage limit for vaccine production or is infected or expressing adventitious agents and development of an assay to monitor for these changes during product production (i.e. cDNA microarrays); 2) development of an animal model to determine if the neoplastic potential of cell substrates is a risk factor for recipients of cell substrate-based products; and 3) development of new and improved (more sensitive) assays for the detection of adventitious agents in the cell lines (i.e. currently unrecognized agents, residual DNA, BSE, latent infectious agents, etc).
- Development, Testing, and Evaluation of Candidate Vaccines Against Plague
 - This initiative will support investigation and comparison of two promising plague vaccines in advanced stages of development. Research will include: conducting comparative studies on immunogenicity in various animal models including nonhuman primate animal models, as well as in Phase I clinical trials; develop and evaluate surrogate markers of protective immunity generated after immunization; optimizing the immunization regimen to enhance the degree and duration of protective immunity for promising vaccines candidates; validate preclinical and clinical assays used for the assessment of protective immunity; and production of cGMP product.

Mr. REGULA. Mr. Kennedy.

Mr. KENNEDY. Mr. Sherwood, does that include the political affiliation of the researcher, too?

Mr. SHERWOOD. No. Or the psychological evaluation.

Mr. KENNEDY. How did you know I was going to come back to that?

I would like to ask Dr. Duke if you could comment on how in the past 2 years HRSA has received approximately \$650,000,000 for its hospital preparedness program, and in the wake of the biological attacks on large civilian populations, of course, the psychological fear and uncertainty that results will be widespread and the panic that ensues is most assured.

So would you explain how HRSA and the Department of Health and Human Services have integrated the psychological and behavioral aspects of bioterrorism preparedness and response with medical preparedness and response by our Nation's hospitals?

Ms. DUKE. In the immediate response to the events of 9/11, the Secretary called together the components, particularly SAMHSA and HRSA, around a coordinated response to the psychological effect of that event on the population at large, but particularly on children. And our Bureau of Maternal and Child Health worked with SAMHSA and with our New York State, for example, grantees around increasing and focusing our attention on the mental health aspects of that, particularly around children, particularly in that neighborhood. And I can develop that more if you would wish.

We also provided—the Congress gave us funds to get to New York, Pennsylvania, and Virginia to assist the folks who responded to the events of 9/11, and we assured that all services were eligible for the reimbursement from those funds.

Additionally, in our guidance that is to come out in the next week or so, we have identified the important component of mental health as an important benchmark for this year's money.

So the issue has not been lost on us as we have been working with hospitals and as we look at the individual State plans, because it is a State-centered approach. We have encouraged the States to focus on that, and most of their plans have done so. Beginning, this year we are stating it as a specific requirement, a benchmark, and we will be monitoring for it.

Mr. KENNEDY. Well, that is good to hear.

Dr. Gerberding, I have been talking with your office and Mike Sage and, of course, Dr. Dole about what the CDC is doing to develop risk communication protocols and develop strategy for building community resilience. Maybe you could comment on how that is going in terms of building community resilience, what needs to be done to prepare for that, whether you have adequate funds.

You know, we talk a lot about—as Dr. Duke said, about the States having their plans, but are we telling the States, listen, there is this money out there for you to incorporate behavioral and mental health responses to your disaster plan? I mean, I know that now Secretary Thompson said, well, they can take advantage of this; but I am wondering is it specifically clear to these folks that this money can hire a person in their State, can help that person coordinate with the hospitals and community centers to get people

prepared, or is this kind of a passive thing that they kind of, if they are lucky enough to find out about, they are on top of it?

Dr. GERBERDING. Let me first say that looking back on the anthrax and the World Trade Center events, I think that at CDC we were not aware of and not fully prepared to deal with the mental health aspects of this, and so I agree with your concern. There are issues for the infected people or the injured people, there are issues for the exposed people, and then there are certainly issues for the affected people—which was most of us—and we need to have preparedness plans in place for all of those groups.

Mr. KENNEDY. And how do you integrate that with the Department of Homeland Security, your plan into—who is talking to one another?

Dr. GERBERDING. We intersect with Homeland Security at a number of levels. At the highest level, very often Secretary Hauer and I and Secretary Ridge and Secretary Thompson are around the table together, with smallpox among many of the policy issues. It is a face-to-face intersection. The stockpile issues have gone extremely well. We have worked out a very effective collaboration there.

But I think in terms of the actual conduct of the public health planning at the State level, we can do more, and you are making me think we should have a formal liaison to our planning committee and probably also our grant review committee, so that that is contained in there.

I have a working group at CDC on mental health issues which includes our psychiatrists and psychologists who are at CDC, although it is a very small group, because that isn't our primary focus, and we do work with SAMHSA on this. We, I think, need to be more explicit in the guidance that we are creating right now for the preparedness of the State grant program, and there is still time to do that. And so I am going to take this message back home and read for myself what is in the current grant guidance and make it explicit if it isn't already, because we need to do that.

Mr. KENNEDY. Thank you.

Mr. Chairman, both Dr. Gerberding and Dr. Duke both mentioned SAMHSA in their answers and yet SAMHSA, I can say again, doesn't get a nickel, doesn't get one nickel in bioterrorism response. It is the lead mental health agency, and it is not at the table. And I am concerned about that.

Mr. REGULA. Well, I would say that a lot of these things are being sorted out. It has been thrust upon us in a relatively short time.

Mr. KENNEDY. Right.

Mr. REGULA. And I suspect that that will be addressed.

Mr. KENNEDY. I think it is cause for concern when we see people buying duct tape and plastic wrap, and that we as a Nation aren't prepared to deal with the most elementary situations. We could have all the stockpiles that we talked all this morning about. We can have all the stockpiles we want, Mr. Chairman, but if people are in panic, how in the world do you expect us to inoculate the people who need to be inoculated, the right people?

We can talk all about strategy that we want, but it is going to be rendered moot if we are not prepared to deal with the behav-

ioral aspects of an attack. And that is the point I will make again and again, and I thank you for your patience in putting up with me.

Mr. REGULA. I am quite sure we will hear from you in the future.

I think in all fairness that the administration, as represented by our witnesses this morning, has done a good job of trying to respond to something in short order here, because we are in a whole new world, and I don't think at this point there is any sense of panic across the land. People have discovered the joys of entertaining at home and staying at home, and perhaps it has strengthened family life in America as a result of events.

I have a concern on accountability. In the statement of managers accompanying the fiscal year 2002, 2003 Omnibus Appropriations Act, the conferees requested a report within 45 days of enactment, detailing the amounts of fiscal year 2002 State and local preparedness funds, and a number of my colleagues have touched on this. Each State—have the States responded? Is this underway? And have you completed the work on the request of the conferees that was in the omnibus?

Mr. HAUER. Mr. Chairman, that is underway. CDC and HRSA collect that, and then that is rolled up. And we should have that available soon, but it is in process.

Mr. REGULA. And we will be getting a copy.

Mr. HAUER. Absolutely.

Mr. REGULA. At the committee for the members.

Are you building in some types of accountability? Because you are sending a lot of money out to States, to health departments, to hospitals. Have you tried to get an assurance that this money will address the problems that potentially exist?

OVERSIGHT OF STATE AND LOCAL PREPAREDNESS GRANTS

Mr. HAUER. Yes, sir. Mr. Chairman, we have built in a 3-tiered system to ensure that the money is being used for what it was asked for, that there are measurable gains, and that the money is being used productively. We basically start with an auditing system that is done of the dollars that are expended. We have an ongoing project monitoring system that includes site visits where we send evaluation teams out to ensure that, among others things, they are not having trouble in accomplishing what they have said they would do. If they are, we have technical assistance teams that are available to help them with various components of the grant to get to where they need to be.

And then, finally, the third tier is an evaluation of the whole program, which is basically outcomes assessment to ensure that the outcomes are those that were expected. And if they were not, then we want to understand why not. We are using some outside assistance to get this done.

We have also asked the Inspector General to work with us on this, and the Inspector General has been doing some audits of the States. So we have a number of eyes looking at this, both from a fiscal perspective and from a technical perspective to make sure that these programs—this is a lot of money that has gone out to the States in a very short period of time, and we want to make

sure that this money at the end of the day is better preparing our Nation to deal with these horrific threats.

Mr. REGULA. Well, I have to say that I have been impressed with your testimony this morning. I think that you give the American public reason to feel a sense of confidence that you are addressing the problem. I would like you to take back to the Secretary our commendation, because it seems to me that given the size of HHS, that his leadership and yours and others have caused this agency, in the disparate parts of it which each of you represent, to work together. And that is ideal. And with the States and the local communities.

And we are maybe moving toward what I have had as a goal, and that is to make the whole system seamless. And that is a challenge, but I guess I get a sense that you are, both internally and in terms of the other parts of our government, both State, local, and Federal, working in that direction. That will mean that the money that we are going to—have been and will continue to appropriate will get spent to give the American public a sense of confidence in their government.

You know, people have some fears of terrorism and its potential impact on their lives, and that is one of the reasons, as I mentioned to Mr. Kennedy, people are staying here. They are concerned.

Even SARS, I have had called from my constituents that should I take that trip? One constituent has an around-the-world trip planned, and he says "I guess I will have to lose my deposit but I am going to," because he had a concern about SARS. And yet I think, Dr. Gerberding, given the short time frame that this has come into the public attention, you have gotten a handle on it, trying to assure the public that they don't need to have total concern about that impact on their lives.

But, again, I am impressed. Let us as a committee be helpful, and communicate to us ways in which we can be part of this process of ensuring the American public that their government is responding to—

Mr. HAUER. Well, thank you, Mr. Chairman. Thanks for your support. I know the Secretary certainly heard your message the other day, when you were visiting, about having a seamless system, and he continues to remind us about that as we move forward. And we will be talking with you and your staff more about that as we move forward. But we certainly appreciate yours and the committee's support, and we will continue.

Mr. REGULA. Well, thank you for coming this morning, and Dr. Gerberding, I hear you had the Red-eye from California in order to be here. We give you a special moment of thanks for making that effort.

Dr. GERBERDING. Thank you. Thank you for indulging me.

Mr. REGULA. You are our team, and we are pleased that you are out there making it work. The hearing is adjourned.

[The following questions were submitted to be answered for the record:]

UPGRADING STATE AND LOCAL PUBLIC HEALTH PREPAREDNESS

Mr. Regula: Dr. Gerberding, much of our preparedness to detect and respond to a biological, chemical or radiological incident depends on the thousands of local health public health departments across the country, how much of the funding for Upgrading State and Local Public Health Preparedness is making it to local health department agencies?

Dr. Gerberding: Based on a recent analysis, CDC estimates that \$377 million is going to local agencies (41% of the total grant of \$918 million).

Mr. Regula: Do you have data on how these funds are being used?

Dr. Gerberding: Yes, CDC documents awards and monitors how grantees use their cooperative agreement funds.

Mr. Regula: If so, please provide the Subcommittee with a table that lists the allocation of funds across the different elements of preparedness (i.e. planning, surveillance, laboratory capacity, communications, information dissemination, and education and training).

Preparedness Planning and Readiness Assessment	\$283 million	Provide strategic leadership, direction and assessment of activities to ensure state and local readiness for bioterrorism. To be able to respond to emergencies caused by bioterrorism through appropriate planning. To effectively manage the receipt of the Strategic National Stockpile (formerly the National Pharmaceutical Stockpile).
Surveillance and Epidemiology Capacity	\$200 million	Be able to rapidly detect a terrorist event through a highly functioning disease surveillance system. States must rapidly and effectively investigate and respond to a potential terrorist event as evidenced by a comprehensive and exercised epidemiologic response plan.
Laboratory Capacity: Biological	\$146 million	Develop and implement a program to provide rapid and effective laboratory services in support of the response to bioterrorism. As a member of the LRN, ensure adequate and secure lab facilities, reagents, and equipment to rapidly identify biological agents.

Laboratory Capacity: Chemical	\$6 million	Develop and implement a program to strengthen laboratory services in support of the response to chemical terrorism.
Health Alert Network/Communications and Information Technology	\$149 million	Provide communication connectivity, emergency communications, protection of data and information systems, and provide secure electronic exchange of public health information.
Communicating Health Risks and Health Information Dissemination	\$41 million	Provide needed health/risk information to the public and key partners during a terrorism event by establishing critical baseline information about the current communication needs.
Education and Training	\$97 million	Ensure the delivery of appropriate education and training to key public health professionals, infectious disease experts, emergency department personnel, and other healthcare providers in preparedness for and response to bioterrorism.

Mr. Regula: How do you plan to monitor the allocation of funds across State and local health departments as well as whether these agencies are meeting performance benchmarks?

Dr. Gerberding: CDC will monitor whether or not grantees meet benchmarks and will monitor grantee level of preparedness and readiness to respond to by collecting semi-annual progress reports from the grantees, by conducting site visits, and by challenging capacities and capabilities of grantees to respond through drills, exercises, table-top simulations of events.

ACADEMIC HEALTH CENTERS

Mr. Regula: A number of you in your written statements make reference to the initiatives involving academic health centers. What do you see as the role of academic health centers in homeland defense?

Dr. Duke: An academic health center is an integral component of a region's health care network. As local, regional and state plans for responding to bioterrorism and other public health emergencies unfold, academic health centers will be seen with multiple roles. An academic health center is often a region's tertiary care center, providing a level of health care needed in a mass casualty situation. They should be included in surge capacity calculations, either as direct care givers of affected

individuals or as recipients of transferred patients. Academic health centers can also be involved in the education and training of health care personnel including both students and practicing providers.

Academic health centers are eligible applicants for the Bioterrorism Training and Curriculum Development Program. The Bioterrorism Training and Curriculum Development Program, funded at \$28 million in FY 2003 and proposed for \$60 million in the President's FY 2004 budget, will equip a workforce of healthcare professionals to address the medical consequences of bioterrorism and other public health emergency preparedness and response issues. In this context, "other public health emergencies" includes other forms of terrorism (such as use of chemical, explosive, incendiary, or nuclear agents against the civilian population) as well as natural disasters and catastrophic accidents. Specifically, the goal of this program is the development of a healthcare workforce that possesses the knowledge, skills and abilities to: (1) recognize indications of a terrorist event; (2) meet the acute care needs of patients, including pediatric and other vulnerable populations, in a safe and appropriate manner; (3) participate in a coordinated, multidisciplinary response to terrorist events and other public health emergencies; and (4) rapidly and effectively alert the public health system of such an event at the community, state, and national level. This training focuses on two populations of providers: (a) the practicing providers thorough continuing education; and (b) those in training programs through curricular enhancement.

Mr. Regula: Is there a role for using academic health laboratories to provide needed surge capacity at the State and/or local level?

Dr. Gerberding: Yes. New grant guidance was recently released that specifically asks grantees to collaborate with academic health centers to develop bio-laboratory capacity.

Mr. Regula: To what extent are Academic Health Centers a part of State bio-defense plans?

Dr. Gerberding: Each grantee was asked to develop a terrorism preparedness and response plan. Where needed, based on the grantees decisions, grantees have included academic health centers as part of the terrorism preparedness and response plans. In addition, the new guidance issued will ask grantees to address the current relationships with academic health centers and examine ways to strengthen the relationship.

In addition, CDC has a cooperative agreement with the Association of American Medical Colleges (AAMC) to strengthen linkages between medicine and public health. The AAMC and its member organizations are valuable assets in strengthening homeland security. The Association of American Medical Colleges represents the nation's 126 accredited medical schools, nearly 400 major teaching hospitals, more than 105,000 faculty in 98 academic and scientific societies, and the nation's 66,000 medical students

and 97,000 residents. The AAMC's Council of Teaching Hospitals and Health Systems (COTH) is composed of approximately 400 major teaching hospitals and health systems. Teaching hospitals are essential "classrooms" for physicians, nurses, and other health professionals and providers.

HOMELAND DEFENSE

Mr. Regula: Funding provided by this Subcommittee for homeland defense is to support activities related to countering potential biological, disease, chemical, and radiological threats to civilian populations. Dr. Gerberding, how much of the roughly \$2.2 billion provided to CDC for FY2002 do you estimate supports bio-preparedness activities and how much do you estimate supports chemical and/or radiological preparedness? What about the funding for FY2003?

Dr. Gerberding: The \$2.2 billion received in FY 2002 represents an unprecedented investment in terrorism preparedness and response activities. Included in this investment was \$918 million sent out to 62 grantees including all 50 states, Washington DC, 3 large cities, and 8 U.S. territories. This investment has supported many preparedness activities including chemical and radiological threats as well as strengthening overall state and local public health capacity for non-terrorist outbreaks of disease and other public health emergencies. For example, the buildup of the surveillance and epidemiologic capacity in states has not only helped prepare for a possible bioterrorist attack, but has allowed states to be better prepared for responding to the West Nile Virus outbreak and monitoring Severe Acute Respiratory Syndrome (SARS) cases across the U.S. Reporting an amount the directly supports only bioterrorism preparedness is difficult, especially when looking at dollars spent by the states for overall preparedness.

Internally, CDC is continuing to prepare for biological, chemical, and radiological threats. Roughly, \$50 million is spent to upgrade CDC capacity to respond to biological threats. CDC spent around \$40 million on chemical and radiological threats. Because of increased funding in FY03, CDC expects increase effort in all areas including biological, chemical, and radiological preparedness.

Mr. Regula: What is your estimate in FY2003 for support of activities related to strengthening the environmental public health response to terrorism? How much is requested for FY2004?

Dr. Gerberding: CDC estimates it will provide \$5.5 million to our state partners to maintain surge capacity for the detection of chemical agents in the environment and an addition \$15.1 million to provide guidance to environmental public health programs and develop a system of sharing best practices for environmental health programs among CDC, state and local environmental health programs. We anticipate FY 04 funding level to remain constant with our current level of funding.

Mr. Regula: What is the status of the creation of an Environmental Health Service Corps program? How much do you estimate the CDC will spend on the program in FY2003? How much is requested for FY2004?

Dr. Gerberding: The status Environmental Public Health Service Corps (EPHSC) program is preliminary. This program can increase the number of highly trained professionals in the field of environmental public health. Additionally, the EPHSC can provide a deployable asset to respond to environmental public health issues related to emergencies including disease outbreaks, natural disasters, terrorism and other public health concerns. Due to the preliminary nature of the program, no funds have yet been spent, but the EPHSC is ready for deployment if funding becomes available.

BIODEFENSE

Mr. Regula: Dr. Zerhouni, how much of the roughly \$1.6 billion NIH estimates will be spent on biodefense in FY2003 do you estimate will support bio-preparedness research activities and how much do you estimate will support chemical and/or radiological preparedness?

Dr. Zerhouni: Immediately following the terrorist events of the autumn of 2001, the National Institute of Allergy and Infectious Diseases (NIAID) launched an expansion of its ongoing program of biodefense research. The focus of this effort has been on basic research and the application of such research to the discovery and development of countermeasures for civilian terrorism utilizing human microbial pathogens or their toxins. From the larger NIH perspective, this initial focus on microbial terrorism was essential and appropriate, given the lead role played by the NIAID in federal biomedical infectious disease research, and I believe that the current allocation of the NIH biodefense R&D budget is appropriate.

I have informed the other Institutes and Centers of the NIH that new biodefense research initiatives or activities addressing other areas of NIH concern (i.e., chemical and radiological/nuclear terrorism, and behavioral/mental health aspects of terrorism) should be addressed within the current budget allocation of those ICs, or they should seek future year "biodefense" increases through the annual budget process.

Mr. Regula: Why is there such a disparity between biological and chemical preparedness amounts? Do you anticipate that the mix among bio and chemical preparedness to vary over time and across States?

Dr. Gerberding: States have chosen to invest their terrorism preparedness resources in a number of activities including chemical and radiological threats. Reporting amounts this way is difficult because overall preparedness efforts support preparation for all hazards. Since states have discretion based on the state's own needs as how funds are allocated across activities, CDC cannot prospectively determine how funds will be allocated in the coming year.

Mr. Regula: Dr. Zerhouni, it is clear why NIH would take the lead in research about countermeasures for biological threats given its long record in viruses and bacterial infection. But it is less clear why NIH is the natural site for research on chemical and radiological threats. From Dr. Gerberding's written statement, it seems that CDC has been very involved in lab work with chemical agents. What experience does NIH have in supporting this type of research?

Dr. Zerhouni: A number of NIH Institutes and Centers support research that is very relevant to the challenges posed in developing countermeasures for radiological and chemical terrorism. For example, the National Cancer Institute has a long history of supporting research related to the prevention of injury to normal tissue resulting from radiation therapy of cancer. Two examples in the arena of chemical injury include research on neurotransmitters supported by the National Institute on Neurological Diseases and Stroke, and research on blood cell growth and development supported by the National Heart Lung and Blood Institute supports basic. While we agree that the NIH will probably not have a predominant role in the total national effort of preparedness for chemical and radiological threats, it is clear that we may have the opportunity to make important contributions in relevant biomedical research to help deal with them.

Mr. Regula: How would NIH's work differ from that of the CDC?

Dr. Zerhouni: The same distinctions between the fundamental roles of the CDC and the NIH that apply in the case of research on biological threats would apply in the case of research on chemical and radiological threats. The NIH supports basic biomedical research and the application of such research to the development of countermeasures through advanced development, involving partnerships with industry and academia. The role of the CDC is more in the areas of surveillance and risk assessment research, and research related to emergency response and preparedness for it.

Mr. Regula: Why would the Allergy Institute take the lead rather than Institutes like Cancer and NIDDK that have experience in radiological exposure?

Dr. Zerhouni: Because of its extensive experience in planning and building a vibrant biodefense research and development research program since the autumn of 2001, the NIAID has taken the initial NIH steps with regard to chemical and nuclear/radiological terrorism. These steps include initiating a meeting with the leadership of the National Academy of Sciences to explore potential areas of collaboration and cooperation, and the convening of two expert panels to help frame the Alandscape@ of biomedical research and development needs in these areas. A number of other ICs also participated actively in these panel meetings.

To facilitate our planning in these and other areas across the NIH, we have established the NIH Coordinating Committee for Biodefense Research, to include Institutes and Centers with substantive commitments to the development of

countermeasures or preparedness for terrorism against the civilian population. NIAD will staff this committee for the NIH, but each IC will work within the context of its own planning and budget processes to develop research agendas and implement research and development programs relevant to its mission.

HOSPITAL PREPAREDNESS

Mr. Regula: Congress provided \$135 million for Hospital Preparedness in FY2002 and \$518 million in FY2003. How do you expect these funds will be used in FY2003?

Dr. Duke: FY 2003 funds will be used to provide a substantial expansion of the bioterrorism hospital preparedness efforts begun in FY 2002. There will be a significant program expansion into the areas of chemical, radiological and explosive terrorism preparedness. In addition, there will be new emphases on hospital laboratory capacity, emergency medical services and mental health. The benchmarks listed below provide examples of the specific types of priorities that the program expects the states to address as part of their FY 2003 implementation efforts.

Mr. Regula: Provide the benchmarks that will be used in FY03. How do you plan to monitor progress towards reaching the established benchmarks?

Dr. Duke: Every six months, a formal progress report is submitted which details activities on all required aspects of the project. Overall program evaluation is thus possible by entering common objective data elements into a program database to define areas needing improvement over the next six months.

Benchmarks for FY 2003 include the following:

- Establish a system that allows the triage, treatment and disposition of at least 500 adult and pediatric patients per 1,000,000 population with acute illness or trauma requiring hospitalization from a biological, chemical, radiological or explosive terrorist incident.
- Upgrade or maintain airborne infectious disease isolation capacity to have at least one negative pressure, HEPA-filtered isolation facility per awardee, to be placed in accord with the findings of the awardee's needs assessments. Such facilities must be able to support the initial evaluation and treatment of 10 patients at a time having a clinical contagious syndrome suggestive of smallpox, plague or hemorrhagic fever, prior to movement to a definitive isolation facility.
- Establish a response system that allows the immediate deployment of 100 or more extra health care personnel per 1,000,000 population in urban areas, and 50 or more health care personnel per 1,000,000 of population in rural areas.

- Develop a system that allows the credentialing and supervision of clinicians not normally working in facilities responding to a terrorist incident.
- Establish a response system that allows the triage, treatment and disposition of 10,000 asymptomatic adult and pediatric patients per 1,000,000 population with exposure to an infectious disease or radiological source requiring medication prophylaxis or immunization within the first four days of a terrorist incident.
- Ensure adequate personal protective equipment to protect 100 or more extra personnel per 1,000,000 of population in urban areas, and 50 or more personnel per 1,000,000 of population in rural areas, during a biological, chemical or radiological threat.
- Ensure that adequate portable or fixed decontamination systems exist for managing 500 patients and health care workers per million population, who have been exposed to biological, chemical or radiological threats.
- Establish a system that allows the provision of short and long-term mental health services to 5,000 adult and pediatric clients and health care workers per 1,000,000 population exposed to a biological chemical, radiological or explosive terrorist incident.
- Develop a mutual aid plan for upgrading and deploying EMS units in jurisdictions they do not normally cover, in response to a mass casualty incident due to terrorism. This plan must ensure the capability of providing EMS coverage for at least 500 patients per million of population per day.
- Implement a hospital laboratory program that is coordinated with currently funded CDC laboratory capacity efforts, and which provides rapid and effective hospital laboratory services responding to terrorism and other public health emergencies.
- Enhance the capability of rural and urban hospitals, clinics, emergency medical services systems and poison control centers to report syndromic and diagnostic data.

Mr. Regula: What kind of oversight is planned by HRSA for State implementation?

Dr. Duke: The program assigns project officers to work with state health department cooperative agreements awardees in implementing their programs. These project officers have special expertise in a variety of areas germane to bioterrorism preparedness issues. Monitoring is done by working with grantees first on any grant conditions or funding restrictions arising out of the objective grant review process. This

is followed by regular review of and comments on implementation plans as the grantee develops them.

Mr. Regula: Please describe for the Subcommittee the President's BioShield proposal.

Mr. Hauer: BioShield has three objectives: The first is to establish a secure funding source for purchase of critical biomedical countermeasures. A permanent indefinite appropriation to DHS is proposed. Funding would be available for production of countermeasures once manufacture of licensable products is judged scientifically feasible. The appropriation would be used only after the President has approved a joint request from the Secretaries of Homeland Security and Health and Human Services.

The second objective is to provide increased authorities and flexibility for the National Institute of Allergy and Infectious Diseases of the NIH to expedite research and development of critical biomedical countermeasures. The intent is to streamline procurement authority, expedite review of grants, contracts and cooperative agreements and bolster authorities for acquisition, construction, and renovation of facilities. It would also expedite professional and personal services contracts and provide flexibility with regard to personnel authority.

The third objective is to establish an FDA Emergency Use Authorization for critical biomedical countermeasures. Based on a threat determination by the Secretary of Homeland Security, the Secretary of Defense, and the Secretary of Health and Human Services would issue an order allowing an unapproved drug or biologic to be used in an emergency. The HHS Secretary must find that there is reason to believe: that the product is effective; that the benefits outweigh the risks; and that there is no adequate alternative. For example, this new authority could be used to facilitate the use of the Aventis-Pasteur smallpox vaccine, a currently unlicensed product, in an emergency. The HHS Secretary could impose certain conditions (e.g., who may administer and to whom, consent requirements, labeling and record keeping) on such emergency use.

Mr. Regula: Where is the proposal in the authorization process?

Mr. Hauer: As of April 9, 2003, S15 was introduced by Senator Gregg on March 11, 2003. It was reported out by the Health, Education, Labor, and Pensions Committee on March 25th and placed on the Senate Legislative Calendar under General Orders. No House bill has been introduced.

Mr. Regula: Why is it essential that funding be mandatory?

Mr. Hauer: Mandatory funding is essential to assure the long-term stability of government funding which can provide the incentive needed for industry to develop, manufacture and maintain a supply of needed countermeasures such as vaccines. With the government as the only buyer, annual appropriation process is too unpredictable to

provide an assurance of stable funding that industry would require before it makes a sizable investment to build the manufacturing capability and conduct the animal and clinical studies needed to license a product.

Mr. Regula: How much does the Department estimate will be spent annually under the President's proposal?

Mr. Hauer: It was estimated that approximately \$6B would be needed over 10 years for anthrax, smallpox and Ebola vaccines and botulinum antitoxins.

Mr. Regula: Will funds under the President's BioShield proposal be available to support the research and development costs of commercially non-viable countermeasures?

Mr. Hauer: As indicated above, Bioshield funding is intended to suggest research and development of medical countermeasures that do not otherwise have a commercial market. It is anticipated that under Project BioShield companies could sell such countermeasures to the government at prices that would include the cost of the later stages of development such as phase 3 human trials and pivotal animal trials.

Mr. Regula: Please describe for the Subcommittee the President's BioWatch proposal.

Mr. Hauer: BioWatch is a federally initiated effort to conduct surveillance for environmental exposures caused by intentional release of biologic agents. The Environmental Protection Agency (EPA) maintains a network of over 4000 air samplers nationwide for monitoring air pollutants. In BioWatch, air samplers in each of several cities have been equipped for 24 hours-per-day monitoring for selected biological agents. Filters from these samplers are removed at least once each day and transported to a designated public health laboratory that participates in the Laboratory Response Network (LRN), where they are analyzed for agents that might be used in acts of bioterrorism (including the causative agents of anthrax and smallpox).

Results from BioWatch will constitute one of many inputs into public health decision-making and national security. The challenge with BioWatch will be for public health officials to interpret signals promptly, deciding on next steps rapidly and prudently. Thus, input from BioWatch could, in certain circumstances (e.g., especially if BioWatch information is coupled with corroborative information from other sources), trigger emergency response and consequence management activities. These emergency response activities would, however, follow well-established procedures, with defined roles and responsibilities, for emergency management and would not be unique to BioWatch.

Mr. Regula: Which agencies are involved in this initiative?

Mr. Hauer: The lead Federal agency for BioWatch is the Department of Homeland Security (DHS). The Environmental Protection Agency (EPA) is providing collection sites and personnel to attend the sample collectors positioned at these sites. The Department of Defense (DOD) is providing collectors, expertise in sample collection and analysis. The DHS National Laboratories, Lawrence Livermore National Laboratory and Los Alamos National Laboratory are providing technical assistance in the R&D aspects during the roll-out period. Formerly part of the Department of Energy (DOE), Los Alamos National Laboratory (LANL) provides site selection and collector placement assistance while Lawrence Livermore National Laboratory (LLNL) provides LRN laboratory sample analysis design assistance and has provided sample analysis capability during the roll-out period. The Department of Health and Human Service's Office of the Assistant Secretary for Public Health Emergency Preparedness (DHHS/OASPHPEP) has provided oversight in the Office of the Secretary for overall DHHS participation in BioWatch. This participation has been in two areas. Firstly, through the LRN laboratories throughout the nation, the Department of Health and Human Service's Centers for Disease Control and Prevention (CDC) has provided guidance, training and materials in support of an integration of sample collection and local public health laboratory sample analysis. Secondly, HHS has facilitated attempts to insure integration of consequence management efforts should a positive determination be made at one or more of the collection sites by facilitating inter-agency regional meetings. OASPHPEP has coordinated efforts through its command center and that at the CDC to provide guidance on an integrated local, state and federal response plan should a biological release event be detected. All the Federal agencies are collaborating with local and state officials to implement this program.

Mr. Regula: How much do you expect will be spent on BioWatch in FY2003?

Mr. Hauer: The Department of Homeland Security has responsibility of the overall spending on BioWatch and the exact figure is being determined by DHS. An estimate to date (March 03) of HHS's expenditures to support the laboratory analysis component is \$1.3 million dollars while a budget estimate for the entire FY2003 period is \$9 million dollars. In addition, monies have been spent to support planning for the consequence management aspects of a positive event, should one occur, and information exchange to support results notification. The BioWatch initiative was not included in the FY03 budget and monies expended to support the initiative have been committed with the assurance from senior officials at DHS that an interagency transfer of funds would take place as soon as the newly created DHS is able to do so.

Overall, HHS's spending for BioWatch will be in three areas:

- Support of LRN laboratory analysis activities at the CDC and state laboratories that are LRN members and have been designated for BioWatch activities;
- Support for information technology to manage data flow and;

- Support for consequence management under public health response planning.

Mr. Regula: How much is requested for FY2004?

Mr. Hauer: No funds have been specifically allocated to support BioWatch in the DHHS FY04 budget. Estimates on funds needed would depend on the number of supported cities, the collection frequencies in these cities, the number of biological agents tested for in each participating city. Duplication of fixed cost investments such as equipment would not be necessary in FY2004 but reagent and personnel costs would continue at comparable rates for comparable levels of efforts.

Mr. Regula: Which appropriated activity will support the BioWatch initiative?

Mr. Hauer: The U.S. Department of Homeland Security is the lead federal agency sponsoring the initiative and expected to ultimately provide the support for BioWatch. In this regard, the CDC's Office of Terrorism Preparedness and Emergency Response is expected to execute a Memorandum of Understanding/Interagency Agreement for reimbursement of costs incurred by CDC on the behalf of Homeland Security.

PRESIDENT'S BIOSENSE INITIATIVE

Mr. Regula: Please describe for the Subcommittee the President's BioSense initiative.

Dr. Gerberding: CDC is seeking to supplement existing surveillance capacity by obtaining information from additional sources. Possibilities include emergency room visits, lab tests ordered, sales of over-the-counter medications, etc.

Mr. Regula: Which agencies are involved in this initiative?

Dr. Gerberding: At the Federal level, CDC has been working with the Department of Homeland Security, the White House Office of Science and Technology Policy (OSTP), DoD's Office of Health Affairs, the Department of Veterans Affairs, and the Department of Energy.

Mr. Regula: How much do you estimate will be spent on BioSense in FY2003?

Dr. Gerberding: Precise spending estimates are not yet developed; CDC's costs will be fully financed in FY 2003 and FY 2004 within existing appropriations/requests for CDC Capacity (through the Public Health and Social Services Emergency Fund).

Mr. Regula: How much is requested for FY2004?

Dr. Gerberding: Precise spending estimates are not yet developed.

Mr. Regula: Which appropriated account will support the BioSense initiative?

Dr. Gerberding: BioSense will be supported by the Public Health and Social Services Emergency Fund.

BIOWATCH

Mr. Regula: What is the involvement of CDC's Laboratory Response Network labs in BioWatch?

Dr. Gerberding: The LRN is a essential component of BioWatch. To date, 30 LRN laboratories have dedicated trained personnel, and LRN-developed protocols for assays to test for six specific biological agents. Twenty state-based laboratories, all LRN members, have full analytic capacity for PCR and are testing air collector samples seven days a week. In addition to these 20 hub testing labs, another 10 labs are involved to a lesser extent with the preparation of air collector filters and shipment of samples to hub testing lab facilities.

CDC support of the LRN has been responsible for the development and production of the PCR assays, distribution of the procedures and test reagents, end user support via website help desk, and logistical supply of laboratory material. In addition, because the BioWatch program has strained lab capacity, the LRN has provided funding for emergency hires to maintain testing operations in the designated state labs. Additional CDC resources were directed in support of start-up requirements, such as laboratory material, information technology, and overall response planning.

Mr. Regula: How much of the estimated cost of this initiative will be spent at the State and local level

Mr. Hauer: An estimated 75% or more of DHHS's budget for costs associated with the FY2003 start up of BioWatch will be spent directly on resource activities at the state and local level. These state and local level expenditures represent funding for FTEs in state laboratories, travel for state and local laboratory workers to the CDC's Atlanta campus for training, development and production of test reagents, distribution of reagents, and provision of other supplies and equipment needed in the testing methodology. These expenditures represent both one-time and recurring costs. As BioWatch prepares to move into FY2004, some costs -- most notably the \$3.5 million for emergency FTEs -- will be shifted to the Department of Homeland Security.

SYNDROMIC SURVEILLANCE SYSTEMS

Mr. Regula: How many states and/or cities are testing syndromic surveillance systems?

Dr. Gerberding: Data from grantees sent to the Association of State and Territorial Health Officials (ASTHO) indicate there are a handful of states are testing syndromic surveillance systems.

Mr. Regula: How much do you estimate is being spent on testing these systems?

Dr. Gerberding: Grantees budgeted for just over \$200,000,000 for activities in Focus Area B (Epidemiology and Surveillance). A small portion of those funds have been used to test syndromic surveillance systems by grantees. The guidance issued to the grantees provided designated "critical capacities" activities that are deemed high priority, and "enhanced capacities" activities to be considered when some baseline level of capacity had been developed. Development and testing of syndromic surveillance systems is considered an "enhanced capacity".

Mr. Regula: Is there any coordination among states and localities testing these types of systems?

Dr. Gerberding: CDC has provided regional meetings for Focus Area B leaders and has encouraged the sharing of tools developed by grantees among the participants. CDC is also developing a document that describes how to evaluate the components of a syndromic surveillance system and has issued an MMWR that describes guidelines for evaluating public health surveillance systems. Finally, we are evaluating how national level data sources might be useful for public health surveillance.

Mr. Regula: How will the Department ensure that federal dollars are not spent in a duplicative fashion testing new systems and approaches?

Dr. Gerberding: CDC has issued the NEDSS and PHIN standards to guide grantees when developing specific electronic disease reporting systems that will meet the recipient activities contained within the guidance of the cooperative agreement. In addition, CDC is developing software for voluntary use by grantees, the NEDSS Base System. Grantees will develop and deploy systems based on the NEDSS standards, or chose to use the NEDSS Base System.

Mr. Regula: How do States and localities learn of the lessons learned by those testing new systems?

Dr. Gerberding: CDC has provided regional meetings for Focus Area B leaders and has encouraged the sharing of tools developed by grantees among the participants. In addition, CDC has convened national conferences for grantees around the National Electronic Disease Surveillance Systems (NEDSS), and the Public Health Information Network (PHIN) - both critical for sharing new information for applications available for public health surveillance. CDC has also convened partner groups to address system compliance with PHIN standards.

CENTERS FOR PUBLIC HEALTH PREPAREDNESS

Mr. Regula: Please describe for the Subcommittee the Centers for Public Health Preparedness program.

Dr. Gerberding: Established in FY 2000, the Centers for Public Health Preparedness (CPHP) Program serves as an integrated national system for improving the capacity of the front-line public health and health care worker to respond to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies. The program is aimed at providing professional workforce development services to personnel at State and local health departments, community-based organizations and other entities charged to carry out CDC programs in general and bioterrorism and infectious disease control and prevention, in particular.

Two types of centers are in place:

1. Academic Centers: Established in accredited schools of public health, these Centers link schools of public health with state and local health agencies and other partners to assess workforce training needs and to develop and to deliver terrorism preparedness and response training.
2. Specialty Centers: Established in a variety of colleges or universities, these Centers focus on specific topic areas or professional disciplines (e.g., bioterrorism, public health law, informatics);

Mr. Regula: How many Centers are involved in the Network?

Dr. Gerberding: Currently there are 24 Centers -- 19 Academic Centers and 5 Specialty Centers. The total number of Centers is expected to increase to 32 in 2003 due to additional funding and Congressional earmarks.

Mr. Regula: Where are the Centers located?

Dr. Gerberding: Academic Centers (funded through CDC's Cooperative Agreement with the Association of Schools of Public Health[ASPH])

1. Center for Public Health Preparedness and Research, Emory University, Rollins School of Public Health, Atlanta, GA
2. Harvard Center for Public Health Preparedness, Harvard University School of Public Health, Boston, MA
3. Heartland Center for Public Health Preparedness, Saint Louis University School of Public Health, St. Louis, MO
4. Illinois Public Health Preparedness Center at the University of Illinois at Chicago, School of Public Health, Chicago, IL

5. Academic Center for Public Health Preparedness, Johns Hopkins University, Bloomberg School of Public Health, Baltimore, MD
6. Center for Public Health Preparedness at Mailman School of Public Health, Columbia University, New York, NY
7. North Carolina Center for Public Health Preparedness, University of North Carolina at Chapel Hill, School of Public Health, Chapel Hill, NC
8. Northwest Center for Public Health Preparedness at the University of Washington, School of Public Health and Community, Seattle, WA
9. Center for Public Health Preparedness, State University of New York at Albany, School of Public Health, Albany, NY
10. South Central Center for Public Health Preparedness, Tulane University School of Public Health and Tropical Medicine, New Orleans, LA, and School of Public Health, University of Alabama at Birmingham, Birmingham, AL
11. University of California at Berkeley School of Public Health, Berkeley, CA
12. Center for Public Health and Disasters, University of California at Los Angeles School of Public Health, Los Angeles, CA
13. Iowa Center for Public Health Preparedness, University of Iowa, College of Public Health, Iowa City, IA
14. Minnesota Center for Public Health Preparedness, University of Minnesota School of Public Health, Minneapolis, MN
15. Academic Center for Public Health Preparedness, University of Michigan School of Public Health, Ann Arbor, MI
16. Southwest Center for Public Health Preparedness, University of Oklahoma College of Public Health
17. University of Pittsburgh Graduate School of Public Health, Pittsburgh, PA, and Ohio State University School of Public Health, Columbus, OH
18. USC Center for Public Health Preparedness, University of South Carolina The Norman J. Arnold School of Public Health, Columbia, SC
19. Florida Center for Public Health Preparedness, College of Public Health, University of South Florida, Tampa, FL

Specialty Centers -

1. Center for Law and the Public's Health—a joint program of Johns Hopkins University, Baltimore, MD, and Georgetown University, Washington, DC
2. Center for the Study of Bioterrorism and Emerging Infections, St. Louis University, St. Louis, MO
3. Center for Leadership in Education and Applied Research in Mass Destruction Defense, University of Georgia, Athens, GA
4. Center for Deterrence of Biowarfare and Bioterrorism, University of Louisville, Louisville, KY

5. National Emergency Response and Rescue Training Center, Texas A&M University, College Station, TX

Mr. Regula: What is the average time period and amount of support per Center?

Dr. Gerberding: Established in 2000, the Academic Centers Program (A-CPHP) was funded through a cooperative agreement with the Association of Schools of Public Health as a 3-year program with awards approximately \$500,000 each. In 2002, additional funding enabled the awards to increase to \$1 million per A-CPHP center. A funding level of \$25 million has been appropriated for the A-CPHP program in FY 2003. Currently, the awards to ASPH for the A-CPHPs are made annually based on available funds. Funding for the specialty centers is made through competitive award or designated Congressional earmarks, for a 1 – 3 year period, with varying levels of funding.

Mr. Regula: Who determines the training needs of public health workers?

Dr. Gerberding: Training needs for public health workers are determined as a result of assessments developed in collaboration by practice and academic partners with guidance from CDC and other federal agencies. CDC and other federal agencies provide information about the content and skills needed for effective practice. State and local agencies determine skill requirements based on the scope of services provided and information from performance evaluations including exercises and drills. Many academic Centers for Public Health Preparedness have worked directly with state and local partners to assess the training needs of the workforce.

Mr. Regula: How are training activities coordinated across the network of Centers?

Dr. Gerberding: Coordination is a central component of the Centers program. The Centers routinely share information with each other through monthly conference calls coordinated by ASPH and CDC. Additional opportunities for coordination are the result of: specific center work plans, semi-annual planning meetings, site visits, progress reports, specialized committees within the program (e.g. evaluation), and participation in national workforce development efforts. CDC is updating its CPHP website and establishing linkages to searchable databases of training resources. ASPH has established a preparedness resource center. Centers are encouraged to provide access to training products as appropriate nationally through the Public Health Training Network and TrainingFinder.org.

Mr. Regula: What are the goals of the Network?

Dr. Gerberding: The goal of the Centers for Public Health Preparedness network is to improve the capacity of the frontline public health workforce to respond to bioterrorism, other infectious disease outbreaks, and other public health threats and

emergencies. A major objective is to establish a sustainable system to support frontline readiness through strengthened partnerships between the practice and academic community.

Mr. Regula: How will you measure the success of the network?

Dr. Gerberding: The Association of Schools of Public Health (ASPH), in partnership with CDC, has developed a workgroup of researchers representing the Academic Centers for Public Health Preparedness. This workgroup has developed an initial evaluation framework and data collection instruments. The finalized framework will guide a common evaluation process across all the Academic Centers for Public Health Preparedness in FY 2004.

The Academic Centers for Public Health Preparedness evaluative framework will focus on the following three areas of assessment:

1. Linkage with state and local programs
2. Technical expertise and assistance to enhance public health practice
3. Contribution to CDC's national efforts

The success of the Specialty Centers for Public Health Preparedness is measured by their ability to provide preparedness training to constituents, as outlined in a work plan developed in partnership with CDC. The Specialty Centers for Public Health Preparedness report on the success of the training with data on the following four elements:

1. What was the Target audience? (*e.g., number of each discipline attending*)
2. What was the Content area? (*Incident Command Systems, Weapons of Mass Destruction, Epidemiology, Risk Communication, Laboratory Systems/Practice, Information Technology, Legal Issues, Mass Casualty Management, Strategic National Stockpile, Mental Health Issues, Worker Safety*)
3. How was training delivered? (*number and types of modalities used*)
4. What were the outcomes? (*e.g., 320 trainees = surge capacity of nurses prepared to administer smallpox vaccine*)

EMERGENCY COMMUNICATIONS SYSTEM

Mr. Regula: What is the CDC's emergency communications system?

Dr. Gerberding: The CDC Emergency Communication System (ECS) is a system created to ensure rapid, effective and consistent communications by CDC in the event of an emergency.

It is comprised of 10 teams based on function or intended audience. The system takes a comprehensive approach to communications, emphasizing that coordination among the functions is essential to ensure efficient use of communication resources in responding to an event. It also emphasizes the importance of the agency speaking and responding in one voice that is in concert with the Department. The individual teams are comprised of communication experts from across the agency. The ECS has liaison with the CDC Office of Terrorism Preparedness and Emergency Response and will have two seats in the Emergency Operations Center, one on the Main Floor that will be the liaison through the ECS Media Team and the other in the Planning Room that will be the liaison through the Content Team. Below are brief descriptions of the teams' functions:

1. Communication Leadership - lead/manage ECS and liaise with DHHS Public Affairs for unified communication strategy;
2. Information Management - will develop and obtain clearance for all emergency health communication products and act as a conduit for information to Dissemination teams;
3. Media - manage all crisis communications with the news media;
4. Communication Research - provide CDC leadership with feedback from key audiences to use in shaping responses;
5. Web - support emergency web-based needs and communicate web activities;
6. Public Response Hotline - disseminate information and resource references to the public using emergency 800 number;
7. Community Health Education - disseminate information to minimize misconceptions, strengthen public confidence and promote behaviors that protect public health;
8. Public Health Workforce Communication - disseminate crisis communications and pursue related public health workforce outreach activities;
9. Clinician Communication - outreach to clinical community and develop clinician communication products; and
10. Policymaker Communication - will concentrate on policy-related communication content and policymaker audiences to ensure that policymakers will have information needed to properly prepare for, and respond to, terrorism emergencies.

Mr. Regula: How much do you estimate the CDC will spend on the system in FY2003 and under the FY2004 request?

Dr. Gerberding: Currently CDC, estimates that approximately \$8.3 million will be spent in FY 2003 directly related to the ECS system, this includes base terrorism activities, activities taken in support of the smallpox vaccination program, and activities supporting SARS. In FY 2004, it is estimated that the base terrorism ECS activities will

cost about \$7.4 million and if additional national emergencies emerge the cost would increase.

Mr. Regula: How much was spent in FY2002?

Dr. Gerberding: In FY 2002, CDC spent \$3.8 million on ECS activities. The ECS was formed in July 2002, so these were start up funds for part of the fiscal year and investment in resource capacities to have available in case of emergency. The ECS use the West Nile virus experience to exercise internal and external capacity. This exercise was very success and identified refinements to be pursued.

Mr. Regula: How do you measure the effectiveness of your emergency communications system?

Dr. Gerberding: The Emergency Communication System (ECS) works as an intermediary between the CDC divisions and teams managing an outbreak or investigation and all the "public" audiences requiring information. These "public" audiences include immediately affected as well as unaffected public, the public health and clinical response communities and policy makers. In addition, we strive to push out information for print and broadcast media at a pace and volume that will maximize accurate and timely transmission to the public.

With this as our function, to determine effectiveness we need to assess the following areas: (1) the public receives information that leads to appropriate actions; (2) the public health workforce, clinicians, and policymakers receive information needed to take appropriate action and provide advice; (3) the media relay information in an accurate and timely fashion; and (4) CDC scientists believe the communication activities are appropriate and serving their needs.

For all but the public audiences, ECS relies on consistent two-way communications with representatives from each of these audiences. Because we have established easily accessible channels of communication, we have found our public health and clinical partners, the media, and our internal clients communicate the degrees to which we are meeting their needs. However, a proposal for a formal, objective data collection system to assess performance and impact is being developed.

The ECS has created both process and outcome data collection tools to track our impact on the public. CDC provided supplementary funding to the Preparedness Center managed by the Harvard School of Public Health to continue the program of public opinion polling initiated by the Robert Wood Johnson Foundation last year. As an illustration, following is a sample of results from a random digit dial telephone survey of a nationally representative sample conducted for the Harvard School of Public Health on April 11 - 15, 2003: 93% have heard of SARS; 32% were concerned that they or someone in their family could get sick from SARS; 89% said that if they came down with flu-like symptoms, it would be important to tell their doctor about any recent

overseas travel; 92% said SARS is a contagious disease; 84% said there is no vaccine for SARS and 51% said there is no treatment; 94% said that if they had SARS they would agree to be isolated for two or three weeks in a health care facility; 85% said the president's executive order to add SARS to the list of diseases for which people can be quarantined does not threaten their personal rights and freedoms.

Findings such as these demonstrate the growing knowledge and understanding of the public. They also enable CDC to monitor the overall impact of our information on the public as well as guide our ongoing communication work.

The ECS also maintains an informal assessment of public reactions by tracking the hundreds of daily calls to the CDC telephone hotline and gauging what topics are of most concern to the largely unaffected public. We routinely create new materials for our website based on this very immediate assessment, as well as the questions that come from the media.

CDC also commissioned several academic studies after the anthrax crisis to examine the impact of CDC's communication. While the results have not been released, preliminary findings contributed to CDC's decision to create the ECS.

ENVIRONMENTAL PUBLIC HEALTH RESPONSE TO TERRORISM PROGRAM

Mr. Regula: Please describe the CDC's Environmental Public Health Response to Terrorism program.

Dr. Gerberding: CDC works with state and local occupational and environmental health professionals to recognize threat sources, prevent adverse health outcomes, implement comprehensive environmental service vulnerability assessments, and apply the most recent information for protecting the health and safety of emergency response personnel. CDC is establishing a nationwide early warning system for rapidly identifying, triaging, and responding to these events in a timely, effective, and integrated manner; developing standard protocols for identifying and responding to events and enhancing communications among local, state, and federal agencies; and enabling health departments to monitor the extent of these illnesses and to identify and track potentially exposed populations. For example, CDC is expanding collaboration with the American Association of Poison Control Centers to broaden their Toxic Exposure Surveillance System (TESS). TESS provides real-time national data related to calls received by Poison Control Centers. TESS data can be evaluated daily to determine whether a chemical or radiological terrorism event may have occurred and what actions are required.

CDC is addressing communication needs for radiation and chemical emergencies. Information to meet public concerns about radiation emergencies has been developed, tested, and posted on the CDC Web site. A core group of agent-specific fact sheets for the public and emergency responders has been developed for 16 high priority

chemicals. CDC is continuing to work with partners to meet the emergency information needs of clinicians, public health agencies, emergency responders, professional organizations, businesses, and the public for chemical and radiation hazards.

CDC and ATSDR staff have been developing emergency operations plans needed to provide technical assistance and emergency response coordination during planning, preventing, responding, and mitigating public health emergencies. CDC is providing guidance to state and local health officials on radiation disease control measures and providing advice on proper medical treatment of victims of terrorist events. CDC also has developed a unique and successful training program for the nation's public health practitioners in collaboration with the Metro Louisville Health Department. This "Community Based Emergency Response Program" offers public health staff from throughout the nation with a forum to learn about public health's role and mission in the emergency response community that can be used to develop robust and effective preparedness and response systems for chemical, radiation, and other public threats in the attendees' own communities.

Representing a unique national and international resource, CDC's environmental laboratory capacity has been expanded to respond to chemical terrorism including detecting exposure, assessing health risks, and providing information that can reduce additional exposures in the event of a terrorist attack.

Mr. Regula: What are the objectives of the program?

Dr. Gerberding: CDC has been conducting a number of ongoing activities related the primary objective of the program, assisting state and local partners in preventing, preparing for, identifying, and responding to chemical and radiological terrorist incidents and threats. Key activities to accomplish this objective include;

1. Establishment of a consolidated NCEH/ATSDR Terrorism Preparedness and Response Coordination Office in order to ensure accountability and coordination of NCEH and ATSDR assets responsible for preparing for and responding to chemical and radiological and other environmental health aspects of any terrorist event.
2. Development of CDC/ATSDR emergency operations plans addressing chemical or radiological incidents.
3. Establishment of a nationwide early warning system to identify, respond to, and monitor intentional chemical poisonings and radiation illness.
4. Upgrading CDC laboratory capacity to respond to chemical terrorism including detecting exposure, assessing health risks, treating affected people, and preventing additional exposure.
5. The preparation of communication materials for a variety of audiences about the health effects of radiation, preparedness for a radiological emergency and 16 high priority chemical agents.

6. Sponsoring consultation with partners to identify practical strategies that hospital emergency departments can use for the management of casualties following a radiological incident. These strategies will provide the basis for CDC guidelines on responding to a radiological incident.
7. Participating in DHHS-wide Table Top exercises to prepare for a possible radiological emergency.
8. Developing training materials and programs to provide support for critical audiences such as emergency responders and health care/hospital personnel through mechanisms such as distance learning, Internet interactive learning opportunities, and educational curricula.

CDC has funded the Council of State and Territorial Epidemiologists (CSTE) to assess state and local capacity to respond to a terrorist attack involving chemical or radioactive substances. CSTE will assess resources and expertise in the following areas: epidemiology, toxicology, medicine, exposure assessment, laboratories, worker health and safety, community relations, and risk communication.

Mr. Regula: What are the funding levels for the program in FY2002, FY2003 and under the budget request?

Dr. Gerberding: In FY 2002, CDC spent \$2.6 million and the projection for FY 2003 and FY2004 is for a similar amount to be expended.

Mr. Regula: Has any analysis of State and local preparedness for the detection of, and response to, a chemical incident been done by the Department or other federal agency? If so, what was found?

Dr. Gerberding: CDC has funded the Council of State and Territorial Epidemiologists (CSTE) to assess state and local capacity to respond to a terrorist attack involving chemical or radioactive substances. CSTE will assess resources and expertise in the following areas: epidemiology, toxicology, medicine, exposure assessment, laboratories, worker health and safety, community relations, and risk communication.

Mr. Regula: Can State and local health departments use the federal state and local preparedness funds to enhance their preparedness to detect and respond to incidents of chemical terrorism? If so, how much do you estimate State and local health departments are devoting to chemical preparedness?

Dr. Gerberding: Yes. States have chosen to invest their terrorism preparedness resources in a number of activities including chemical and radiological threats. Reporting an amount that directly supports only bioterrorism preparedness is difficult, especially when looking at dollars spent by the states for overall preparedness.

Mr. Regula: Has the Department established benchmarks regarding chemical preparedness?

Dr. Gerberding: CDC currently has benchmarks for the State and local terrorism and emergency preparedness program. There are seven general benchmarks that involve planning; two for epidemiology and surveillance, one for biological laboratory capacity, two for information technology and communications, one for risk communication, and one for education and training.

CHEMICAL TERRORISM PROGRAM

Mr. Regula: What is the goal of your Laboratory Response to Chemical Terrorism program?

Dr. Gerberding: The goal of CDC's Laboratory Response to Chemical Terrorism is to rapidly analyze blood and urine specimens from affected or potentially affected persons to 1) identify the chemical agent(s) used, 2) determine who has been exposed, and 3) determine the amount of exposure for each exposed person. To that end, the laboratory has developed the Rapid Toxic Screen which can measure 150 chemical agents in blood and urine that are likely to be used in chemical terrorism. The Rapid Toxic Screen is a large laboratory effort that utilizes the majority of the mass spectrometry instrumentation, facilities, and personnel of CDC's Environmental Health Laboratory. In response to a chemical terrorism event, samples from the first affected persons will be analyzed using the Rapid Toxic Screen for 150 chemical agents within 36 hours to identify the agent used. This individual exposure information will substantively assist public health management of populations of people who have been or exposed or may have been exposed. In addition to identifying exposed persons, this exposure information is especially helpful in reassuring the large number of people who worry they have been exposed, but in fact have had negligible or no exposure.

Mr. Regula: What are the estimated funding levels for FY2002, FY2003, and FY2004?

Dr. Gerberding: For FY 2002, \$18 million was spent on laboratory response to chemical terrorism and for FY 2003 and 2004, the estimate is also \$18 million.

Mr. Regula: Are these activities funded out of funds provided in your general appropriation account or from PHSSEF funding?

Dr. Gerberding: The funding for this program comes from the Public Health and Social Services Emergency Fund.

Mr. Regula: How much of the funding remains at CDC and how much is distributed to state public health laboratories?

Dr. Gerberding: In FY 2002, CDC awarded just over \$7 million in funds to state public health laboratories in California, Michigan, New Mexico, New York, and Virginia to extend federal capacity. CDC is providing training to these laboratories to

improve their ability to measure chemical agents in response to a terrorist attack involving chemical agents. In FY 2003, the monies available to the states under the large terrorism cooperative agreement can be used by the states to help upgrade their chemical laboratory facilities. Since CDC has not received the states' plans for the money, no estimate is available for how much money states will expend on upgrading their chemical laboratory facilities.

HEALTH ALERT NETWORK (HAN)

Mr. Regula: Please describe the Health Alert Network (HAN).

Dr. Gerberding: The Health Alert Network Program, a component of the Public Health Information Network, is a joint local/state/federal initiative to build a nationwide network of strong public health agencies to serve as the nation's frontline of defense against terrorism and other public health threats. The overall goal of the program is to strengthen the capacity of local health departments - with state, federal, and private partners - to serve as an early warning and response system for the nation. The Health Alert Network Program will help to ensure that local health departments have rapid and timely access to emerging health information and new knowledge for frontline professionals and can effectively use and translate data and information into effective health action.

The Health Alert Network Program is being implemented in phases, designed to meet the most critical needs of local public health departments. In the first phase, all 50 States, three large cities, Washington, D.C. and eight territories received limited, initial funding to strengthen the core infrastructure for information access, communications, and training at the community level; five local health departments received increased funds to develop innovative approaches to local preparedness. In the second phase, health agencies will leverage these efforts and investment to create, translate, and share new knowledge, deliver "just-in-time training" to health professionals, mobilize community partnerships, and develop and test new public health practices.

Currently, all states and territories now participate in the Health Alert Network Program.

Three basic building blocks are being completed nationwide:

1. Continuous, high-speed internet connectivity to support rapid information access,
2. Broadcast capacity to support emergency communication,
3. Distance learning infrastructure to support "just-in-time" training.

The Health Alert Network Program can now reach 1 million recipients nationwide within minutes. As of April 2003, CDC has used the Health Alert Network Program to deliver 134 messages and to train 1.5 million health professionals on such

topics as SARS (Severe Acute Respiratory Syndrome), bioterrorism, West Nile virus, patient safety, and smallpox vaccination.

State and local health officials now use the Health Alert Network Programs within their jurisdictions on an ongoing basis to supplement CDC's messages and training and to provide additional information and services customized for their populations. The system seeks to cover 90% of the population by FY 2003, 95% of the population covered by FY 2004, and 100% of the population covered by FY 2005.

Mr. Regula: How many years has the CDC supported the Network?

Dr. Gerberding: The Health Alert Network (HAN) Program has been supported for four years.

Mr. Regula: What were the original objectives of the Network?

Dr. Gerberding: As originally outlined in a report to United States Senate Appropriations Committee in September, 1998, the objectives of the Health Alert Network Program are to:

1. Develop and implement a staged plan to assure linkage of local health departments to the Internet by the year 2000 for instantaneous, electronic access to CDC and state health departments, neighboring and remote local health departments, local hospitals and doctors' offices, public health laboratories, public safety networks, and other public and private organizations.
2. Help local public health workers become "information technology literate" and able to use such tools as computers, databases, and electronic networks in preventing, detecting, and responding to infectious disease outbreaks and other health threats in the community.
3. Help to assure that local public health workers are trained in the critical skills needed for front-line community health practice and program management, for example, prevention and response planning; detecting and investigating infectious disease cases; identifying children at risk for poor health; monitoring the quality of health care provided in the community; accessing public health laboratory testing services; and educating the community about effective health promotion strategies.
4. Help build lasting training capacity - including cost-effective distance learning systems - to upgrade the skills of local health workers on a continuing basis and prevent recurrence of the gap now looming between the limited resources of local health departments and the health threats they are charged to address.

Mr. Regula: Have those objectives changed over time?

Dr. Gerberding: The overall goal of the Health Alert Network Program remains unchanged: to ensure that local health departments have rapid and timely access to emerging health information and new knowledge for frontline professionals and can effectively use and translate data and information into effective health action. Specific outcome measures have been developed for the original objectives as the Health Alert Network Program evolves and grows. Outcome measures for FY 2004 are:

1. Complete the connectivity and functionality of the Health Alert Network.
2. Ensure that the entire public health workforce has access to training and distance based learning programs implemented or supported by CDC.
3. Establish at least one Advanced Local Practice Site in each state.

Mr. Regula: How are HAN activities distinct from activities supported by State and local preparedness funds?

Dr. Gerberding: HAN funds are provided to state and local public health agencies through the Public Health Preparedness and Response for Bioterrorism grant program and is essential to and interrelated with Focus Area E of the grant program to provide communication connectivity, emergency communications, protection of data and information systems, and provide secure electronic exchange of public health information.

Mr. Regula: How were HAN funds distributed in FY2002?

Dr. Gerberding: The HAN funds were distributed to 55 awardees based on the FY 2001 awards. These awards were distributed above the \$918 million that was part of the supplemental bioterrorism cooperative agreement funds.

Mr. Regula: How will HAN funds be distributed in FY2003?

Dr. Gerberding: In FY 2003, funding will be included in the terrorism preparedness cooperative agreement in order give the awardees as much flexibility as they need to meet the emerging preparedness needs in their areas. Language in the continuation guidance will direct State HAN grantees to spend no less than 85% of the HAN funds at the local level.

HAND-HELD DEVICES

Mr. Regula: Mr. Hauer, I understand that the Office of Science Technology and Policy (OSTP) has distributed an advisory strongly recommending against the use of hand-held tests by first responders. I further am advised that this advisory was based, at least in part, on recommendations of the CDC.

Mr. Hauer: Representatives from 14 federal agencies were convened by the Office of Science Technology and Policy (OSTP) and led by the GSA to address the issue of the use of hand held devices in mail rooms concerned with possible anthrax powder contamination. A limited study of the equipment available was conducted at the CDC at the request of the FBI. The results of these tests indicated that for *Bacillus Anthracis*, the causative agent for anthrax, the evaluated devices were neither sensitive nor specific enough to be suitable to make public health decisions. These devices also provided no ability to determine if the agent was alive (viable) and thus could possibly pose a health risk to individuals or communities. On the basis of these results and partly in response to numerous episodes of false positives from these devices, causing inappropriate and costly response efforts on the part of emergency response agencies throughout the federal government an advisory was released by the Office of Science Technology and Policy. Dr. John H. Margur, of the Office of Science Technology and Policy, on July 19, 2002, released a memorandum to all federal mail managers and first responders concerning the use of these devices. This advisory counseled against the use of these devices in public health emergency response decision making until such time as their sensitivity and specificity warrant their appropriate use and that any such diagnostic testing be utilized only as only one component of a comprehensive health risk determination by law enforcement, public health, emergency response personnel and elected officials in developing an appropriate response plan.

Mr. Regula: What is the Department and/or CDC's view about the role of these testing devices in an overall national response plan for bioterrorism preparedness?

Mr. Hauer: The devices tested to date displayed quite a range of sensitivity (how much is present) and specificity (exactly what the material is) for detecting the various suspected biological agents. In no case did these devices determine if the material is alive and thus may pose a potential infectious threat to humans, animals or agriculture. The appropriate role or place for these devices as part of an overall response and protection scheme is not clear and has not as yet been determined by industry or by government. There is no ongoing mechanism currently in place to evaluate the relative or absolute ability of these devices to meet the claims of their manufacturers, let alone their suitability to serve as the basis for health care decisions for individuals or groups of individuals. Establishment of suitable performance standards may be helpful in allowing both device manufacturers and consumers to have a framework upon which to make decisions in regard to the development, sales and use of such devices.

Mr. Regula: Does the OSTP advisory cover both federal and non-federal agencies? If not, what is the guidance provided federal agencies concerning these hand-held testing devices?

Mr. Hauer: The guidance covers federal agencies only. The guidance, located in Appendix E, at <http://www.ostp.gov/html/GSAAanthraxGuidelines.html> is as follows:

“STATEMENT BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES”

Regarding Hand-Held Assays for Identification of *B. Anthracis* Spores

Purpose

To provide law enforcement, fire services, emergency managers and other first responders with guidance regarding the purchase and use of hand-held assays used for detecting anthrax spores and other biological agents.

Summary

The U.S. Department of Health and Human Services at this time recommends against use by first responders of hand-held assays to evaluate and respond to an incident involving unknown powders suspected to be anthrax or other biological agents.

Background

In recent months, Federal, State and local first responders have had to evaluate numerous samples of white powdery substances to determine if *B. anthracis* (anthrax) spores are present. In some cases, field tests showed an apparent “positive result and this led to the quarantine, isolation or decontamination of people. When these samples were referred to a reference lab in the Laboratory Response Network (LRN), they were found to be negative through microbiological culturing and molecular methods. The devices used for the initial field tests included tickets and strips from at least four vendors. Problems resulted from a variety of factors, such as testing of caustic or harsh chemicals or the performance of tests by inadequately trained personnel.

Discussion

Biological agent field test kits are, at this time, not sufficiently accurate for on-scene decision making in the field. Besides the high number of false positive results, hand-held assays also yield negative results on samples that are truly positive (false negatives). In formal terms, the sensitivity of such assays are in the range of 100,000 spores whereas a culture may detect one spore.

In contrast to situations with chemical exposure where rapid decision making (minutes) can be crucial to the protection and treatment of individuals, there are no examples of biological exposure where decision-making cannot wait for the results of validated laboratory procedures (1-2 days). Any perceived benefit of using currently available hand-held assays fall short of the costs of unnecessary remedial actions and amplified public concern.

No Federal agency certifies or approves these devices. The FBI and CDC have recently evaluated commercially available hand-held assays for the detection of *B. anthracis*. These studies confirm the low sensitivity of such assays and their potential to produce

false-positive results with non-anthrax bacteria and chemicals. The performance of handheld assays for the detection of biological agents other than *B. anthracis* has not been evaluated and their use is also not recommended at this time.

Conclusions

Until results are obtained that would warrant the use of hand-held assays, DHHS recommends:

- (1) hand-held assays systems not be used for the assessment of suspected biological samples;
- (2) Whenever a biological agent is suspected, a unified command should assess the credibility of the situation and determine an appropriate response. The unified command should include fire services, public health, the FBI's Weapons of Mass Destruction Coordinator, and law enforcement;
- (3) Substances that are found to be a credible public health threat by the unified command should be screened in the field for volatile organic compounds (VOC), pH, explosives, and radiation, and then sent to an appropriate laboratory in the Laboratory Response Network (LRN) for testing. First responders and local public health programs need to establish protocols to provide this support and logistics of the response. Besides testing of samples in an LRN laboratory, the protocol should include a system for identification and follow-up of the potentially exposed population and a joint communication plan for the public and media relations. Since exposure to airborne anthrax spores is potentially life threatening, all credible threats should be handled appropriately in a timely manner.

References:

1. "CDC Health Advisory: Hand-Held Immunoassays for Detection of *Bacillus anthracis* Spores." October 18, 2001
<http://www.bt.cdc.gov/DocumentsApp/Anthrax/10182001HealthAlertPM/10182001HealthAlertPM.asp>
2. "Use of Onsite Technologies for Rapidly Assessing Environmental *Bacillus anthracis* Contamination on Surfaces in Buildings." CDC MMWR Vol 50 Number 48. December 7, 2001. <http://www.cdc.gov/mmwr/PDF/wk/mm5048.pdf>
3. "Approved Tests for the Detection of *Bacillus anthracis* in the Laboratory Response Network." <http://www.bt.cdc.gov/DocumentsApp/Anthrax/ApprovedLRNTests.asp>.

EIS PROGRAM

Mr. Regula: How much do you estimate CDC will spend on the EIS program in FY2003? How much is requested for FY2004?

Dr. Gerberding: CDC estimates it will spend \$14.6 million in FY 03 on the EIS program and around \$14.2 million in FY 2004.

SMALLPOX VACCINATION PROGRAM

Mr. Regula: Please describe CDC's expected activities in FY2003 regarding the voluntary civilian smallpox vaccination program.

Dr. Gerberding: The goal of smallpox preparedness is to ensure federal, state, and local health agencies have optimal capacity to respond to a smallpox outbreak. In FY 2003, CDC issued smallpox preparedness program guidance for those states and other jurisdictions receiving funds through CDC's bioterrorism cooperative agreement, for both post-event (or post-attack) and pre-event preparedness activities. The pre-event activities focused on implementing the smallpox civilian vaccination program. As of April 18, 2003, 33,644 public health and health care workers have received smallpox vaccine through this program. One thousand seven hundred ninety-three hospitals, 36% of the nation's acute care hospitals, have had at least one staff member vaccinated. The program has been marked by a relatively low level of adverse events after vaccination, with the exception of unanticipated cardiac disease events. CDC is actively investigating the degree to which smallpox vaccination is associated with these adverse events.

CDC will issue continuation guidance for the bioterrorism cooperative agreement, which will recommend further smallpox preparedness activities, so that increased focus on all the elements needed to assure acceptable levels of preparedness occurs. Based on knowledge of the disease and public health response strategies needed to control and contain an outbreak of smallpox, the following preparedness elements will be addressed:

1. Preparing key responders before an event occurs,
2. Rapid detection, identification, investigation and response to suspect or confirmed cases of smallpox, and
3. Protection of the public including provision of mass vaccination clinics.

In the event that a grantee is comfortable with the level of implementation of the "Pre-Event Response Plan", grantees may begin training and vaccination of additional key public health and healthcare response personnel and first responders that may be put in harm's way if there were a case of smallpox anywhere in the world. These may also include hospital and other health care personnel who may have occupational risk for smallpox infection. Training and vaccinating key individuals before an event may allow for rapid implementation of mass vaccination clinics if warranted.

Mr. Regula: How much does CDC estimate it will spend on the program in FY2003 and FY2004?

Dr. Gerberding: The internal CDC cost estimate for this program is around \$26 million in FY 2003. It is unclear how much will be needed for this program in FY 2004 since estimates are changing rapidly due to the changing scope of the vaccination program.

Mr. Regula: Are these funds provided through PHSSEF funds, from DHS, or through your regular appropriation?

Dr. Gerberding: These funds are provided through the PHSSEF.

STRATEGIC NATIONAL STOCKPILE

Mr. Regula: Now that the funding provided in FY2003 has been transferred to the Department of Homeland Security, please describe CDC's role in the Strategic National Stockpile.

Dr. Gerberding: On 1 March 2003, the Strategic National Stockpile (SNS) was transferred to the Department of Homeland Security (DHS). Below is a description of responsibilities for each department:

DHS is responsible for:

1. Deploying the SNS
2. Pre-positioning SNS inventory
3. Authorizing the transfer of SNS materiel
4. Defining SNS goals and performance requirements
5. Funding SNS activities
6. Acquiring SNS assets

The Department of Health and Human Services is responsible for:

1. Pre-emergency, day-to-day management of the SNS
2. Defining the SNS' content and quantities, with DHS consultation

ROCKY MOUNTAIN LABORATORY

Mr. Regula: Provide the completion dates for construction of the Rocky Mountain Laboratory, the NIAID facility at Ft. Detrick, and the bioterrorism and infectious diseases building on the NIH campus.

Dr. Zerhouni: The completion date for construction of the Rocky Mountain Laboratory is November 2005, for construction of the NIAID facility at Ft. Detrick is December 2006, and for construction of the bioterrorism and infectious diseases building on the NIH campus is October 2005.

CONTINUING EDUCATION

Mr. Regula: What share of the HRSA curriculum development funding in FY04 is expected to be used for continuing education versus incentives for curricular reform?

Dr. Duke: It is expected that 85% of the funds will be used for continuing education and 15% for the curricular reform or expansion of ongoing efforts in curricular development.

Mr. Regula: How many weeks or months is a continuing education course expected to take?

Dr. Duke: The funding period for the Bioterrorism Training and Curriculum Development Program is two years. The duration of any one course is to be determined by several factors to include the method of delivery, the extent of the discipline specific competencies to be attained, and the number of professionals to be trained. It is expected that the training supported with these funds will not only focus on the discipline specific knowledge, skills and abilities needed to recognize, treat and efficiently report instances of a terrorist event or other public health emergencies, but will also prepare the learners to participate in a multidisciplinary terrorist response reflecting a two-tiered approach. Each course of study shall include both discipline-appropriate clinically oriented material and the team collaboration/coordination skills necessary to respond to terrorist events and other public health emergencies. These activities will outline the integrated professional roles and responsibilities inherent in a community response and may include participation in drills, exercises and/or simulations occurring in the state or regions.

Mr. Regula: What types of institutions will be awarded these grants?

Dr. Duke: The types of entities eligible to apply for this program are academic health centers, other public or private nonprofit accredited or licensed health professions schools, and other educational entities such as professional organizations and societies, private accrediting organizations, and other nonprofit institutions or entities including faith-based organizations and community-based organizations; and multi-state or multi-institutional consortia of various combinations of these eligible entities.

NON-BIODEFENSE BENEFITS

Mr. Wicker: What types of non-biodefense benefits have been or will be realized due to the research the NIH and CDC are conducting for bioterrorism protection and readiness efforts?

Dr. Gerberding: Bioterrorism preparedness and response programs have improved CDC's surveillance, laboratory, response, and communications systems. Expanded surveillance capacity as a result of bioterrorism preparedness efforts will help in monitoring the course of existing as well as new and emerging diseases such as SARS and West Nile Virus. The bioterrorism program has improved our ability to diagnose known as well as unknown agents through pathogen discovery programs. This enhanced pathogen discovery program was instrumental in the quick identification of the SARS-coronavirus. The Laboratory Response Network, part of the bioterrorism preparedness program, has developed the capacity to do a variety of diagnostic testing and will soon receive assays for SARS. Protocols developed in the field have proved helpful in preparing and responding to SARS and the education and communications programs associated with the bioterrorism program have improved and fine tuned our ability to effectively communicate with the public, as well as the public health, medical, and other communities. The new state-of-the-art emergency operations center at CDC embodies this new strength and has served as the focus for SARS-related activities and response.

Dr. Zerhouni: The positive long-term benefits for other diseases that will result from the large investment in both basic and translational research in biodefense will be substantial. Research on the microbial biology and pathogenesis of these organisms will enhance understanding of other more common and naturally occurring infectious diseases, both in the United States and around the world. Advancements in the arena of diagnostics, therapeutics, and vaccines will improve our ability to diagnose, treat, and prevent major killer-diseases, such as malaria, tuberculosis, HIV/AIDS, and a spectrum of emerging and reemerging diseases, benefitting people around the world. Basic research will greatly enhance our understanding of the molecular and cellular mechanisms of the innate immune system and its relationship to the adaptive immune system, and lead to improvements in the treatment and prevention of immune-mediated diseases, such as systemic lupus erythematosus, rheumatoid arthritis, and other autoimmune diseases. Finally, improved understanding of the mechanisms of regulation of the human immune system will have positive spinoffs for diseases such as cancer, immune-mediated neurologic diseases, and allergic and hypersensitivity diseases, as well as for the prevention of rejection of organ transplantation. Specific examples include:

- Research on Smallpox.....several different research networks, which were formed to develop medical interventions to combat smallpox, are being mobilized to help research and develop medical interventions for SARS. For instance, the Clinical Antiviral Study group-developed a network of clinical trial

site investigators that could rapidly treat persons, under a treatment IND, in the event of a smallpox outbreak. This same system is currently being mobilized to develop a treatment protocol for SARS. Drug screening networks developed to identify and test drugs that could be used to combat smallpox and other potential biological agents of terror are being called into action to develop in vitro screening tests for SARS therapeutics.

- Research on Anthrax.....research into understanding how anthrax toxins devastate healthy cells has led to a possible new strategy to fight cancer. This potential treatment strategy works by having an altered form of an anthrax toxin become activated only by contact with an enzyme that is on the surface of virtually all tumor cells. Once activated, this anthrax toxin is able to start devastating the tumor cells. In mouse studies, several different types of tumors dramatically shrunk after being injected with the altered toxin, but the normal cells were left alone.

BIOTERRORISM

Mrs. Northup: There has been a dramatic increase in funding for bioterrorism preparedness since September 11th. Tremendous amounts of money have been and will be poured directly into states through the Departments of Homeland Security and Health and Human Services. What measures are being taken to track this funding and ensure that it is being properly utilized at the state level?

Mr. Hauer: HHS has defined the focus of the cooperative agreements unequivocally: preparedness for bioterrorism, other outbreaks of infectious disease, and other public health emergencies. Within this scope, in FY 2002 we specified 17 Critical Benchmarks and other longer-term objectives. In FY 2003 there are a total of 45 benchmarks: 25 for CDC, 15 for HRSA and 5 that are cross-cutting in nature, integrating CDC and HRSA funded activities.

In implementing the program in FY2002, HHS struck a carefully considered balance among speed, flexibility, and accountability: speed in getting the funds into the hands of the appropriate State officials, flexibility for the States with respect to how they approach HHS-specified objectives; and accountability of the States for responsive and responsible use of the funds. Workplans submitted by states had to address the critical benchmarks for which funding would be used in achieving. In instances where the HHS review identified deficiencies in the States' plans, the associated funds remained restricted in the interest of prudent stewardship. CDC and HRSA followed up immediately with the affected States to define the actions needed to remedy the deficiencies and to offer technical assistance as appropriate. These efforts continued, and the remaining restricted funds were released on a case-by-case basis as the States provided evidence of successful remediation.

Looking ahead, HHS plans a variety of additional steps toward ensuring that the cooperative agreements achieve their goals. It is requiring progress reports at approximately six-month intervals. CDC and HRSA, in conjunction with OASPHEP, will initiate a program of site visits to enable first-hand determinations of the States' progress toward the Critical Benchmarks and other objectives of the cooperative agreements. Further, from time to time, HHS will sponsor conferences, workshops, and other forums for its cooperative agreement partners with the intent of highlighting best practices and identifying specific areas where the States require technical assistance. The HHS Office of the Inspector General (OIG) is providing a uniquely valuable complement to the project monitoring efforts summarized above. The OIG recently completed an audit of CDC's cooperative agreement with California and, based on this pilot project, is developing a guide to assist State auditors in making comparable financial reviews in their States.

HHS staff will be alert to detect activities that do not seem to fall within this framework and will work with the States as necessary toward ensuring that all activities under the cooperative agreements are appropriate uses of funds.

Should HHS staff detect ineffective uses of funds under the cooperative agreements, we will work with the States to redirect the funds to appropriate uses and to effect whatever remedial actions are indicated. Should HHS staff detect apparently unlawful uses of funds under the cooperative agreements, we will not hesitate to impose funding restrictions and require corrective actions, to disallow errant expenditures, to redirect or recover misspent funds, and/or to refer cases for possible investigation by the HHS Office of the Inspector General.

Mrs. Northup: Last year, Mr. Allen conveyed concerns with available resources at state and local levels for adding staff and planning and development programs. Training, vaccine distribution, patient surges, and communication were among his chief concerns. Are these resource needs being adequately addressed?

Dr. Gerberding: Yes. The increase in the support of CDC grantees has increased staffing, planning activities, program development, training, communications connectivity, and enhanced planning for distribution of stockpile material, including vaccines, for all 62 grantees.

Dr. Duke: We think with the substantial increase in funding for the Hospital Preparedness program in FY 2003 and proposed for FY 2004, that these needs are being addressed. Funding in FY 2002 was at a level of \$135 million. Funding in FY 2003 was raised in the appropriation to \$514.6 million and funding for FY 2004 is proposed for \$518 million. This will allow the States to address such resource intensive needs as the development of surge capacity for hospitals, development of communication systems and implementation of training programs.

Mrs. Northup: Are states receiving specific guidance on the types of bioterror implementation programs to be utilized?

Mr. Hauer: Yes. CDC and HRSA have issued guidances in both FY 2002 and FY 2003 for developing and implementing public health and hospital preparedness efforts. Within the guidances, the agencies identify priority areas for states to address. They also provide critical benchmarks that states are required to meet in developing the capacity to prepare for and respond to bioterrorism and other public health emergencies. This year, FY2003, HHS has also established "cross-cutting benchmarks" for the states to address. These cross-cutting benchmarks will ensure that all preparedness activities – both public health and hospital – are coordinated and integrated at the state and local levels. The HHS cross-cutting benchmarks are: 1) Incident management; 2) Joint advisory committee for CDC and HRSA cooperative agreements; 3) Laboratory connectivity; 4) Laboratory data standard; 5) Jointly funded health department/hospital activities.

While benchmarks are provided to the states, HHS does not dictate precisely how each state should go about meeting these benchmarks. Our intent is to identify the "what they need to do," not "how they should do it." This approach allows individual states to plan and implement activities in a manner that is locally appropriate and feasible.

Mrs. Northup: Do your agencies endorse any one program in particular?

Mr. Hauer: Neither CDC nor HRSA advocate one specific program. They issue guidance to support state and local jurisdictions and the health care community in implementing their plans for bioterrorism and other public health emergencies. The guidance provides areas of emphasis that states must address when planning for and responding to acts of terrorism.

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

Mrs. Northup: The naturally occurring international outbreak of Severe Acute Respiratory syndrome has highlighted the importance of preparing the U.S. public health system for a possible bioterrorism attack. How would you rate the response of global and national health systems to this crisis?

Dr. Gerberding: Since the beginning of the SARS outbreak, WHO has coordinated an international investigation that has produced unprecedented scientific and epidemiologic discoveries with unprecedented speed. WHO issued a global alert concerning SARS on March 12 and on March 14, CDC activated its emergency operations center (EOC) to support the response of WHO to this global threat.

By March 24, scientists at CDC and in Hong Kong announced that a new coronavirus had been isolated from SARS patients. Within days, the new virus had been sequenced and posted on web sites globally.

Since then, almost instantaneous communication and information exchange has supported every aspect of the response. Up-to-the-minute information has been tailored for a variety of audiences, and interim guidance has been issued and frequently updated as new information becomes available.

Despite the tremendous effort and efficient speed with which the investigation of the SARS outbreak has been conducted, it is entirely too soon to predict its ultimate scope and magnitude. Only time will determine whether it develops into a global pandemic or whether SARS will develop a seasonal pattern improving prospects for regional containment.

Mrs. Northup: How are your agencies utilizing this outbreak to mobilize and prepare for the possibility of future attacks, deliberate or otherwise, targeting public health?

Dr. Gerberding: Some of the lessons learned in the current outbreak of Severe Acute Respiratory Syndrome (SARS) that can be applied to bioterrorism preparedness include:

1. Isolation procedures can be implemented. CDC has provided isolation and infection control guidelines to health care workers, SARS patients and their close contacts, schools, workplaces, and others. CDC would respond similarly in a bioterrorism event.
2. Appropriate and timely risk communication allays public fears and prevents public panic. An informed public is more likely to cooperate with necessary public health measures when they understand the reasons for implementation of the measures. In a bioterrorist event, keeping public fears and panic to a minimum will be of utmost importance in order to contain and control the spread of a communicable disease.
3. Adjusting staffing levels to maximize Agency response while minimizing fatigue and burnout by rotating team members and leaders during the response as appropriate.
4. Using CDC's Laboratory Response Network (LRN) to disseminate diagnostic reagents as soon as they are standardized and available.
5. Fine-tuning our approach to contact tracing for airplane exposures within the current smallpox plan. During the SARS investigation, CDC has faced a daunting challenge of trying to track lists of passengers potentially exposed to SARS. Airlines do not keep these manifests electronically and there is a significant time delay between exposure and receiving passenger lists from the airlines.
6. The SARS outbreak investigation provides CDC with an unexpected opportunity for a tabletop exercise providing a variety of scenarios similar to what would be expected in the advent of a bioterrorist attack or an influenza pandemic.

Not only will many of the lessons learned from the SARS outbreak assist in planning for bioterrorism preparedness, but many of the systems already in place to respond to a bioterrorist attack have proved useful in responding to SARS. These measures include:

1. Activation of CDC's Emergency Operations Center (EOC). Coordination of the SARS outbreak investigation via the EOC maximizes CDC's response to the epidemic.
2. Deployment of trained Emergency Response Teams to assist in the international investigation.

3. Channels of communication set up via various communication teams responding to a variety of audiences are facilitating the quick dissemination of up-to-date information on SARS. These channels were already in place due to advanced bioterrorism preparedness and response planning.

PUBLISHING RESEARCH PAPERS

Mr. Weldon: In response to my question about exercising restraint in publishing certain studies Dr. Fauci indicated that the scientific journal publishers are working with the National Academy of Sciences (NAS) to develop guidelines and a process for bringing greater scrutiny to decisions over whether or not to publish studies that might aid those who would seek to cause us harm through the use of biological or chemical agents. I would like for you to expound on this further. Please provide the guidelines and processes that have been put in place by the publishers and the NAS for reviewing sensitive studies.

Dr. Fauci: In January 2003, the NAS sponsored an open forum for journal editors, scientist-authors, government officials, and other interested parties to explore the many issues related to the possibility that new information published in research journals might give aid to those with malevolent ends. While this problem is too complex to be solved quickly, the NIH applauds the positive steps that have already been taken by journal publishers and the NAS, along with other professional organizations, to address this significant issue.

Mr. Weldon: Is the Department of Homeland Security, the Centers for Disease Control, the Department of Health and Human Services, and/or the National Institutes of Health involved in these processes and reviews?

Dr. Fauci: No, not the reviews of articles. Journal peer reviews are independent assessments that Federal agencies do not (and should not) directly influence. We are working with the journals, as one of many partners, in developing guidelines.

Mr. Weldon: If so, to what degree?

Dr. Fauci: Please see answer to question (b). As I indicated in my testimony, we are working with many organizations to develop guidelines.

Mr. Weldon: To date are there studies that have been scrutinized through this process that have not been published due to national security considerations?

Dr. Fauci: Several journal editors have reported instances in which certain information was not published because of security concerns, but I believe that the numbers have been small.

Mr. Weldon: In those instances in which a federal agency involved in homeland security questions a decision to publish a taxpayer funded study, who makes the final decision - the publication, the researcher, or the federal agency that provided the funding?

Dr. Fauci: To date we have not had to confront this matter. The final decision to publish a paper that has been submitted to a journal is the journal editor's decision, which is why they are in an extremely important leadership position on this issue. Again, we commend the journals and the scientific community for the proactive steps they have taken to date.

ADVANCED RESEARCH PROGRAM

Mr. Obey: The budget for the Office of the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP) includes \$5 million for "Advanced Research" in both FY 2003 and FY 2004. Please explain how these funds are being used in FY 2003 and how they will be used in FY 2004. In particular, what portion will be used for personnel and other expenses for research oversight and supervision, what portion will be used for grants or contracts for research projects, and what portion will be used for other purposes?

Mr. Hauer: OASPHEP's Advanced Research program provides oversight and supervision to vaccine acquisition contracts at CDC and research efforts at NIH and FDA. At present the Office oversees and coordinates programs for current and second generation smallpox vaccines, vaccinia immune globulin, anthrax vaccines and botulinum antitoxins. The office provides policy guidance and planning for the advanced development and acquisition of medical countermeasures to bioterrorism, including antibiotics and antiviral drugs.

Of the \$5 million appropriated in FY 2003, \$1.6 million will cover personnel and support costs, \$935,000 is programmed for use by CDC for smallpox professional education, \$500,000 is committed to a study of influenza vaccine manufacturing by cell culture methods (which will be a contract from NIH), and \$400,000 is committed to supporting modeling studies of control of smallpox outbreaks through a contract managed by the Fogarty International Center at NIH. The remaining \$1.5 million is committed to a contract to support OASPHEP in executing the BioShield acquisitions program.

The OASPHEP is expected to be responsible for managing the large contracts with manufacturers for the acquisition of bioterrorism countermeasures including second generation anthrax vaccine, second generation smallpox vaccine, botulinum antitoxins, and others. As a result of greatly increased management responsibilities there will a significant increase in the portion of the FY 2004 budget allocated for oversight and supervision.

Mr. Obey: To the extent that "Advanced Research" funds are used to support research grants or contracts, what types of research will be conducted and why is this research funded through ASPHEP rather than NIH, CDC, or another appropriate operating division of the Department?

Mr. Hauer: Advanced research funds are used for one time special studies such as the smallpox modeling project and studies of influenza vaccine economics that directly impact the policy considerations by OASPHEP. OASPHEP transfer funds to the operating divisions, such as NIH and CDC, which then award the contracts.

Mr. Obey: The budget for OASPHEP also includes \$9.5 million for International Early Warning Surveillance in both FY 2003 and FY 2004. Please describe the specific activities being carried out with these funds in FY 2003 (e.g., stationing HHS personnel overseas, grants to foreign governments and non-governmental organizations for epidemiology and lab capacity, etc.) and the specific activities expected to be undertaken in FY 2004, and indicate how funding is divided among these activities.

Mr. Hauer: The goal of the International Early Warning Surveillance Program is to strengthen the capabilities of the U.S. Department of Health and Human Services (HHS) and our partner agencies in nations in the developing world in the early detection, investigation, and reporting of disease outbreaks caused by organisms which not only constitute a significant indigenous threat to public health but also, if employed by terrorists, could threaten U.S. national security.

The framework for the program includes the following objectives: (1) appropriate training of clinical and public health personnel; (2) enhanced epidemiologic and laboratory capacity for early detection and control of infectious diseases; and (3) maximal use of appropriate information technologies to ensure effective communications among local, regional, and international stakeholders.

To accomplish the above program goals, HHS is pursuing a two-part strategy, using FY 2002 and FY 2003 funds.

- We will establish bilateral agreements with selected partner nations to improve their disease surveillance capabilities through: (a) technical assistance, including on-site assignment of expert HHS epidemiologists and laboratorians; (b) training for epidemiologists and laboratorians in the partner nations; and (c) access to laboratory equipment, reagents, and information technology to upgrade regional infectious disease surveillance infrastructure.
- Integration with multinational efforts led by the World Health Organization (WHO) and Pan American Health Organization (PAHO) to strengthen early detection of disease outbreaks through enhancement of existing epidemic intelligence systems that collect and promptly verify reports of disease outbreaks. The WHO and PAHO programs will be integrated to enhance national infectious disease surveillance and promote timely communication, information sharing, and response.

Using FY02 and FY03 funds, HHS will strengthen WHO's Global Outbreak Alert and Response Network and PAHO's Latin American and Caribbean regional surveillance networks. Specific program activities include, but are not limited to, underwriting of dedicated contracts for the air transport of specimens, upgrades of information technology, and the training and equipping of disease outbreak response teams.

Some activities will also be carried out in cooperation with the Global Health Security Action Group, an eight-country consortium (U.S., Canada, United Kingdom, Mexico, Japan, Italy, France, and Germany) founded by Secretary Thompson in the fall of 2001 with the aim of better collaboration on bioterrorism preparedness.

Mr. Obey: What is the relationship between the ASPHEP International Early Warning Surveillance activities and global health and disease surveillance activities carried out by the CDC?

Mr. Hauer: While CDC plays an important role in responding to and controlling infectious disease outbreaks, in the years ahead regional disease surveillance networks must grow in number and geographical scope to insure global health security. In the long run, regional and disease-specific networks should expand, interact, and evolve into a global "network of networks" that helps ensure early warning of new and re-emerging threats and increased capacity to monitor the effectiveness of public health control measures. This will be accomplished by building on the strengths of the CDC's pre-existing disease surveillance and control activities, as well as other U.S. Government programs. To achieve the goals of this program, a broad inter-agency perspective is required.

The Office of the Assistant Secretary for Public Health Emergency Preparedness (OASPHEP) with assistance from the Office of Global Health Affairs, will coordinate and direct the International Early Warning Surveillance Program which integrates existing systems mentioned above into an operative system detailed below. The importance of coordination of information and working together in response efforts could not be better exemplified than by the current global SARS outbreak. The International Early Warning Surveillance Program will not only strengthen coordination efforts during future public health crises, but will also encourage integration of planning and preparedness efforts so as to reduce the disease burden. The reason OASPHEP is managing this program is because of the compelling need to fully integrate the various areas of technical, scientific and policy expertise across all the relevant agencies within HHS, especially the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA) and National Institutes of Health (NIH). Additionally, the program requires complex collaboration with other U.S. Government agencies such as the Departments of State, Homeland Security, and Defense at the headquarters level. Furthermore, other critical partners in this program include the WHO, the eight-member Global Health Security Action Group, non-government organizations, academic institutions and non-profit sector organizations.

The approach we have proposed will be in harmony with the general strategic architecture of the U.S. domestic approach to bioterrorism preparedness and will feature as much as possible the adaptation of U.S. tools and methods to international situations. Laboratory protocols will be harmonized with pre-existing CDC protocols to produce common standards, and disease surveillance systems, such as for polio eradication and influenza surveillance, which will serve as models. The laboratory system at the

Caribbean Regional Epidemiology Center will be "twinned" with a model state public health lab in the U.S. Laboratory Response Network (LRN) with higher-level assistance available from CDC. Additionally, U.S. public health technical experts will be placed in settings where they can serve on the ground in critical regions as mentors and consultants with the expectation that they will build relationships of trust with those on the front lines in outbreak detection and response. In some locations, such as Kenya and Thailand, the existing CDC Emerging Infectious Disease centers will form part of the International Early Warning Surveillance Program.

Mr. Obey: What are the specific activities to be carried out with the ASPHEP funding for the Media/Public Information Campaign?

Mr. Hauer: This public information campaign is currently in the development stages. The campaign will focus on educating the general public about the variety of biological and chemical agents that exist and how best to prepare oneself to minimize the dangerous effects of these substances. The campaign will build upon the basic information on these agents currently available from the CDC as well as upon currently available basic preparedness guidance. The goal of the campaign is to educate the public in a constructive manner that informs and provides useful information without alarming the population.

EMERGENCY PREPAREDNESS FUNDING

Mr. Obey: Please indicate the actual or planned uses of the funds provided to CDC through the Public Health and Social Services Emergency Fund in FY 2002 and FY 2003 and in the President's FY 2004 budget request, by providing a table similar to the one that appears on page 94 of the hearing print from the FY 2003 hearing on HHS bioterrorism preparedness efforts.

Dr. Gerberding: The information follows:

Centers for Disease Control and Prevention			
FY 2002-2004 Terrorism and Emergency Activities Funding			
(Dollars in Millions)			
	FY 2002 Final	FY 2003 Estimate	FY 2004 President's Budget
Upgrading State and Local Capacity			
--Consolidated State Grants	\$865.0	\$859.4	\$865.0
-- Health Alert Network	\$34.0	\$33.8	\$34.0
-- Laboratory Capacity--Chemical	\$8.2	\$8.1	\$8.0
-- Technical Assistance & Oversight	\$11.7	\$11.6	\$11.7
-- Centers for Public Health Preparedness	\$20.0	\$24.8	\$20.0
-- Partner Cooperative Agreements	\$1.3	\$1.2	\$1.3
Subtotal, State & Local Capacity	\$940.2	\$938.9	\$940.0
Upgrading CDC Capacity			
-- Smallpox Vaccination Plan	--	\$23.70	--
-- Select Agents	\$5.5	\$5.4	\$6.4
-- State/Local Technical Assistance & Oversight	\$8.7	\$8.6	\$10.1
-- Preparedness & Response	\$66.1	\$65.7	\$76.7
-- Laboratory Capacity	\$33.4	\$33.3	\$38.7
-- Surveillance & Epidemiology	\$15.1	\$15.1	\$17.5
-- Research	\$5.5	\$5.5	\$6.4
-- Anti-Infective Agents	\$2.0	\$2.0	\$2.3
Subtotal, CDC Capacity	\$136.3	\$159.3	\$158.1
Anthrax	\$18.0	\$17.9	\$18.0
Security Improvements	\$46.0	\$19.9	--
Critical Recovery Efforts	\$7.50	--	--
Strategic National Stockpile*	(\$645.00)	(\$298.10)	(\$300.00)
Smallpox*	(\$512.00)	(\$99.40)	(\$100.00)
Department of Homeland Security Transfer	--	(\$0.60)	
Total, Terrorism & Emergency Activities	\$1,148.00	\$1,135.40	\$1,116.10

*The Strategic National Stockpile and Smallpox activities transferred to DHS in FY 2003. The FY 2002 Total reflects a comparable number to FY 2003.

Mr. Obey: What specific formula was used to allocate FY 2002 funds among the various states, territories and large cities under the CDC cooperative agreement program for enhancing state and local bioterrorism and public health emergency preparedness? In particular, I believe the formula involved a combination of a flat dollar amount per state plus a per-capita amount; if that is the case, what were those amounts?

Dr. Gerberding: The FY 2002 bioterrorism cooperative agreement with the 50 states, Washington DC, 3 large cities, and 8 US territories totaled \$918 million, an unprecedented investment in preparing state and local governments against a possible bioterrorist attack. This money was distributed on a formula basis with each state, Puerto Rico, and the 3 large cities receiving a base amount of \$5 million, with Washington DC receiving a base amount of \$10 million. The base amount assured a level of preparedness regardless of the size of the state. The remainder was then placed into a per-capita formula based on population, so the more populous states received proportional funding. Finally, the remaining territories including the US Virgin Islands, Guam, American Samoa, and the Freely Associated States were allocated \$3 million to make sure the outlying US territories also were preparing for a possible bioterrorist attack. Altogether, the 62 awardees received a total of \$918 million and this money is being used to enhance state and local bioterrorism and public health emergency preparedness.

Mr. Obey: Do you anticipate changing that formula (or the dollar amounts used in the formula) in FY 2003 and/or FY 2004? If so, how?

Dr. Gerberding: The FY 2003 award will be a continuation of the FY 2002 supplemental bioterrorism cooperative agreement funds, so the same basic formula of a base amount, plus a per capita funding formula will remain the same. No determination has yet been made regarding the distribution of FY 2004 funding.

Mr. Obey: What do you consider to be the specific provisions of authorizing law governing or guiding the allocation and use of the funds appropriated to CDC (through the Public Health and Social Services Emergency Fund) for upgrading state and local capacity to respond to terrorism?

Dr. Gerberding: CDC has general authority to assist State and local authorities in the prevention of communicable diseases under § 311 of the Public Health Service Act [42 USC § 243] and to make grants to States and their political subdivisions under § 317 of the PHS Act [42 USC § 247b]. In addition, CDC has specific authorities to assist states and local jurisdictions to prepare for bioterrorism and other public health emergencies under §§ 319A, B, C, F, & G of the PHS Act [42 USC §§ 247d-1, 2, 3, 6, 7], as amended by the Public Health Security and Bioterrorism Response Act of 2002, Pub. L 107-188.

TERRORISM PREPAREDNESS PROGRAMS

Mr. Obey: Please provide an update on the activities CDC is undertaking - and the activities that CDC plans to undertake in FY 2004 - to improve preparedness to deal with possible chemical terrorist incidents and threats.

Dr. Gerberding: CDC has been conducting a number of ongoing activities related to assisting state and local partners in preventing, preparing for, identifying, and responding to chemical and radiological terrorist incidents and threats:

Emergency chemical and radiological incident public health response

- CDC has been assisting state and local occupational and environmental health service professionals to: recognize threat sources, prevent adverse health outcomes, implement comprehensive assessments of vulnerabilities, and apply the most recent information for protecting the health and safety of emergency response personnel, such as respirators and personal protective equipment. CDC is also working with state and local partners, professional organizations and business partners, to develop a CDC emergency operations plan for providing technical assistance and emergency response coordination for state and local jurisdictions and for preventing, responding to, and mitigating public health emergencies.

Nationwide system to identify, respond to, and monitor intentional chemical poisonings and radiation illness

- Chemical poisonings and radiation illnesses are not routinely reported to public health officials, but may be the only warning of an intentional chemical agent or radioactive release. CDC has been working to: create a nationwide early warning system for rapidly identifying, triaging, and responding to these events in a timely, effective, and integrated manner; develop standard protocols for identifying and responding to events and enhancing communications among local, state, and federal agencies, and other partners such as the poison control systems; and enable health departments to monitor the extent of these illnesses and to identify and track potentially exposed populations.

Emergency communication for radiation and chemical events

- CDC has addressed communication challenges for bioterrorism emergencies and begun to address communication needs for radiation and chemical emergencies. Information to meet public concerns about radiation emergencies has been developed, tested, and posted on the CDC Web site (<http://www.bt.cdc.gov/radiation/index.asp>). Many identified gaps remain in information for emergency responders, clinicians, public health agencies, and the public. CDC is continuing to work with partners to meet the emergency information needs of clinicians, public health agencies, emergency responders, professional organizations, businesses, and the public for chemical and radiation hazards.

Public health preparedness, planning and readiness assessment

- CDC has been providing technical assistance to implement comprehensive environmental service vulnerability assessments and operational improvements to equipment and processes. CDC and ATSDR staff have been developing emergency operations plans needed by CDC/ATSDR to provide technical assistance and emergency response coordination during planning, preventing, responding, and mitigating public health emergencies.

Critical FY 2004 Activities

Consolidated CDC/ATSDR Office of Chemical and Radiological Terrorism Preparedness and Response (OCRTPR)

- This proposal creates a consolidated CDC/ATSDR Office of Chemical and Radiation Terrorism Preparedness and Response (OCRTPR). The OCRTPR will provide leadership, coordination, and accountability by assuring a public health workforce that is ready and responsive in the event of an intentional chemical agent or radiation release. The office will manage and coordinate related activities in ATSDR and CDC and work collaboratively with federal, state, and local health departments, and other relevant partners.

Environmental Health Management

- CDC, in collaboration with ATSDR and other Federal agencies proposes to develop and implement Environmental Health Management, an initiative to improve the capacity of the public health emergency response system to detect and remediate health hazards associated with environmental contamination due to terrorism and other public health emergencies. So far, specific Environmental Health Management issues that CDC has had a major role in addressing are

Community-based emergency response program

- CDC is implementing a state-of-the-art Emergency Preparedness and Response Assessment Program designed to assist and train state, local, and other federal health and environmental agencies to respond to terrorist events and other emergencies. In partnership with other Federal agencies, the assessment will develop a series of scenarios, descriptions of goals and objectives, operational procedures, and other exercise materials. In addition, it will run exercises or other tailored training programs. Eligible participants for the exercises will be states and local health departments that have completed the Community Based Emergency Response Program in Louisville, Kentucky, and are prepared for assessment of their response system.

Toxin and Radionuclide Response Laboratory

- The CDC/NCEH laboratory has been assigned a task of developing a new method to measure botulinum toxin in blood and urine. This laboratory would also measure toxins such as ricin, saxitoxin, and selected other toxins that can be used in a terrorism event. In addition, this laboratory would develop measurements for human exposure to radionuclides that are likely to be used in dirty bombs.

Providing training and proficiency testing to state laboratories

- State laboratories need to develop rapid and effective laboratory response capabilities to address chemical terrorism. The outcomes of this project are to develop state capacity for the provision of more rapid access to clinical samples for measurement, selected analytical capability at the state level, and surge capacity for CDC to respond to a large-scale chemical terrorism event. To help state labs achieve this capacity, CDC will provide training at CDC for state laboratories. In addition, CDC will conduct proficiency testing programs for the states to assess their performance in measuring chemical agents and assure acceptable accuracy, precision, sensitivity, and specificity.

Mr. Obey: Similarly, please provide an update on the activities CDC is undertaking - and the activities that CDC plans to undertake in FY 2004 - to improve preparedness to deal with possible radiological or nuclear terrorist incidents and threats.

Dr. Gerberding: CDC has a long-established working relationship with the states on emergency response in the event of a nuclear plant accident or terrorist event. CDC staff members have coordinated with other federal agencies in planning and conducting emergency response drills covering a variety of scenarios, such as detonation of a nuclear weapon, a terrorist attack on a nuclear facility, or deliberate release of radioactive material. Since September 11, 2001, we have been working on several projects to address the increased threat of a radiological terrorist event.

CDC has prepared a wide variety of information for about the health effects of radiation and preparedness for a radiological emergency. This information, including facts sheets and brochures for the general public, emergency responders, physicians, and public health officials, is available through CDC's web site (<http://www.bt.cdc.gov/radiation/index.asp>).

CDC has consulted with health professionals, primarily in emergency department settings, and state and local health department representatives to identify practical strategies that hospital emergency departments can use for the management of casualties following a radiological incident. These strategies will provide the basis for CDC guidelines on responding to a radiological incident. CDC is currently working to improve hospital communications in the event of a radiological emergency.

A CDC/ATSDR Radiation Working Group prepared a report assessing CDC/ATSDR's preparedness and response roles and responsibilities as they relate to a radiological terrorist event and to our capacity to respond to a variety of radiation terrorist scenarios. We are working with the Food and Drug Administration to address concerns about the recommended potassium iodide dosing that would help protect infants in the event of an emergency involving radioactive iodine. CDC's radiation experts are working with the Strategic National Stockpile staff to assess whether additional supplies are needed to be prepared for a radiological emergency.

CDC is assisting the Office of the Assistant Secretary for Public Health Emergency Preparedness at HHS its Radiation Terrorism Concept of Operations Plan and has participated in a DHHS-wide exercises to prepare for a possible radiological emergency. We will continue to participate in exercises in which key federal and state agencies respond to radiological and biological terrorism events.

The agency is also developing training materials and programs to provide support for critical audiences such as emergency responders and health care/hospital personnel through mechanisms such as distance learning, Internet interactive learning opportunities, and educational curricula. DC has developed and implemented a training course entitled "Radiation Truth and Consequences: A Course for Clinicians and Scientists" for the Readiness Force of the U.S. Public Health Service Commissioned Corps.

In FY 2004. Additional activities include the following:

Additional activities include the preparation of reference material for Advisory Teams to use during radiological emergencies. The Advisory Team was established by the Federal Radiological Emergency Response Plan (FRERP) and includes representatives from several federal agencies. This Team uses environmental and radiological measurements from the Federal Radiological Monitoring and Assessment Center (FRMAC) and other available sources to support and advise state and local governments on protective action guides (PAGs) which are currently under development for the affected population.

Mr. Obey: Am I correct in understanding that CDC's laboratory preparedness role with respect to chemical, radiological or nuclear terrorism is largely limited to analysis of human clinical samples? Which federal agencies currently have primary responsibility for analysis of environmental samples for chemical, radiological or nuclear agents?

Dr. Gerberding: CDC's laboratory role does focus on clinical samples (blood and urine) to analyze for chemical and radiologic agents to determine what chemical or radiologic agents have been used, who has been exposed, and how much exposure they have had. For chemical agents, FDA has primary responsibility for food sample analysis and EPA has primary responsibility for other environmental samples. Discussions are

ongoing with EPA to clarify their emergency role and coordinate analyses across CDC, FDA, and EPA so that appropriate samples are obtained and laboratories exchange information on results that could help with analyses.

Mr. Obey: What is the role of the Agency for Toxic Substances and Disease Registry (if any) in improving preparedness to deal with potential biological, chemical, radiological or nuclear terrorism?

Dr. Gerberding: ATSDR is involved in a coordinated effort with CDC to prepare to deal with future terrorist attacks – primarily those involved with chemical terrorism. Some of the preparedness areas where ATSDR is already working include:

- Emergency Operations Center – ATSDR provides staff to both CDC and the Secretary of HHS' Emergency Operations Center to provide support for GIS mapping capabilities – a critical tool for tracking events and directing response activities effectively.
- Rapid Response Registry – ATSDR has been given the responsibility to design and implement a registry of all individuals exposed during a terrorist event. We are developing the tools to provide support to state and local public health staff to identify and enroll all exposed and potentially exposed individuals as quickly as possible after a terrorist incident.
- On-Site Response Teams – Teams including ATSDR personnel along with other CDC staff will enable us to give on-site recommendations on the health effects of toxic substances to first responders and local health officials – and to give diagnosis and treatment recommendations to emergency hospital personnel for exposed patients.
- Chemical Information – ATSDR has widely distributed copies of its "Managing Hazardous Materials Incidents" to physicians, hospitals, and other health response workers. These materials give guidance on appropriate protective measures for specific chemicals, as well as providing diagnosis and treatment advice.
- Surveillance Systems – ATSDR currently supports 15 states to track acute chemical releases into the environment and the health effects caused by these releases. It is a real-time monitoring system that provides data on chemical releases that could signal a possible terrorist attack. We have plans to expand that program to cover additional states.
- Training – ATSDR participates in multiple preparedness training exercises each year.
- Chemical Antidotes – ATSDR has been asked to work within HHS and with the Department of State to review potential new antidotes to chemicals that could be used in terrorist attacks.

Mr. Obey: Please provide an update on your goals for development of the Laboratory Response Network, in terms of measures such as the number of labs participating at each level and the capabilities of those labs. Where does the network stand now relative to those goals? What further progress toward those goals do you hope to make in FY 2003 and FY 2004?

Dr. Gerberding: LRN labs are currently described as "Sentinel" labs (formerly Level A) which are primarily the local hospital and diagnostic laboratories throughout the country. There are nearly 25,000 of these laboratories that need to be a part of their own state laboratory network and the LRN has challenged each state to develop a method to reach out and incorporate these laboratories into a documented state network. "Reference" laboratories (formerly Level B and C) are represented by 117 facilities that provide confirmatory testing for bioterrorism and for other public health emergencies. Our goal is to continue to oversee the maturity of the LRN as more veterinary, food, environmental, and chemical laboratories are added.

Specifically, by FY2004, CDC targets:

- adding 8 veterinary laboratories to the LRN
- having variola-specific testing available in all states with Biosafety level 3 capacity
- doubling the capacity for botulinum testing
- introducing a dual-level approach to chemistry testing in the LRN by the end of 2004
- facilitating the addition of 3 food testing laboratories to the LRN

Today, the LRN consists of 117 LRN reference laboratories distributed throughout all 50 states. There are now 50 biosafety level 3 labs (BSL-3) which include state and local labs, federal labs, and military labs located in 35 states. Of these, 33 state laboratories report being at BSL-3 which is nearly three times the number reported in 1999.

LRN sites across the country have improved their facilities and increased their capabilities, illustrated by the number of labs that can now employ rapid testing methods for specific agents.

- Today, 116 LRN labs can perform confirmatory tests for *Bacillus anthracis* (anthrax) using state-of-the-art testing methods and platforms, none of the state labs reported in 1999 using PCR to isolate anthrax;
- Today, 110 LRN labs can perform confirmatory tests for plague using state-of-the-art testing methods and platforms. While more than half of the labs were able to perform traditional isolation tests in 1999, none used PCR.
- Today, 74 LRN labs can perform rapid confirmatory tests for vaccinia in order to differentiate between a true smallpox infection (variola) and an adverse reaction to the smallpox vaccine.

- Today, 109 LRN labs can perform rapid confirmatory tests for *Francisella tularensis* (tularemia).
- Today, 22 LRN labs can perform rapid confirmatory tests for botulinum toxin (botulism).
- Today, 51 LRN labs can perform rapid confirmatory testing for *Brucella*.

Mr. Obey: Please provide an update on the National Laboratory System demonstration project.

Dr. Gerberding: The Laboratory Response Network is charged with ensuring that the nation's public health laboratories can test for biological and chemical agents used for terrorism. The National Laboratory System Initiative seeks to develop tailored, systematic approaches to improve communication, coordination and collaboration among federal laboratories, state public health laboratories and clinical laboratories to improve all public health testing.

CDC has funded four state pilot projects in Michigan, Minnesota, Nebraska and Washington, in which the state public health laboratory has developed methods to improve clinical laboratory preparedness, working relationships, and communications between colleagues in the medical care system.

Mr. Obey: Please provide an update on progress made in implementing the Health Alert Network, and indicate what further progress you plan to make during FY 2003 and FY 2004.

Dr. Gerberding: The Health Alert Network Program, a component of the Public Health Information Network, is a joint local/state/federal initiative to build a nationwide network of strong public health agencies to serve as the nation's frontline of defense against terrorism and other public health threats. The overall goal of the program is to strengthen the capacity of local health departments - with state, federal, and private partners - to serve as an early warning and response system for the nation. The Health Alert Network Program will help to ensure that local health departments have rapid and timely access to emerging health information and new knowledge for frontline professionals and can effectively use and translate data and information into effective health action.

The Health Alert Network Program is being implemented in phases, designed to meet the most critical needs of local public health departments. In the first phase, all 50 States, three large cities, Washington, D.C. and eight territories received limited, initial funding to strengthen the core infrastructure for information access, communications, and training at the community level; five local health departments received increased funds to develop innovative approaches to local preparedness. In the second phase, health agencies will leverage these efforts and investment to create, translate, and share new knowledge, deliver "just-in-time training" to health professionals, mobilize community partnerships, and develop and test new public health practices.

Currently, all states and territories now participate in the Health Alert Network Program.

Three basic building blocks are being completed nationwide:

- Continuous, high-speed internet connectivity to support rapid information access,
- Broadcast capacity to support emergency communication,
- Distance learning infrastructure to support "just-in-time" training.

The Health Alert Network Program can now reach 1 million recipients nationwide within minutes. As of April 2003, CDC has used the Health Alert Network Program to deliver 134 messages and to train 1.5 million health professionals on such topics as SARS (Severe Acute Respiratory Syndrome), bioterrorism, West Nile virus, patient safety, and smallpox vaccination.

State and local health officials now use the Health Alert Network Programs within their jurisdictions on an ongoing basis to supplement CDC's messages and training and to provide additional information and services customized for their populations. The system seeks to cover 90% of the population by FY 2003, 95% of the population covered by FY 2004, and 100% of the population covered by FY 2005.

Mr. Obey: Please provide an update on progress made in implementing the National Electronic Disease Surveillance System (NEDSS), and indicate what further progress you plan to make during FY 2003 and FY 2004. Among other things, please indicate the number of states and localities receiving funding for assessment and planning, or for development of their own systems meeting NEDSS standards, or for deployment of elements of NEDSS.

Dr. Gerberding: To date, all states, six cities, and one territory have received awards to assess their existing systems and to develop plans to implement NEDSS-compatible systems. By sometime in 2003, 48 states and 5 cities will receive funds to develop one or more of the NEDSS architectural elements and/or to implement the NEDSS Base System (NBS). In FY 2004, CDC will continue to deploy NEDSS to the remaining states and complete work on a number of NEDSS Modules. Support of the system will continue including corrections, enhancements, and additional functions.

Mr. Obey: What is CDC's role in evaluating and/or issuing standards for rapid "field tests" for detection or identification of biological or chemical threat agents?

Dr. Gerberding: There are a very large number of potential chemicals that could need detection methods. This mandates a large number of standards and validated procedures. Prioritization of these chemicals is on-going.

Mr. Obey: What activities has CDC undertaken in this area and what have been the results?

Dr. Gerberding: The criteria for evaluating direct reading devices for biological, gas and vapor agents, and for respirator break-through sensors, are still under development.

OCCUPATIONAL HEALTH

Mr. Obey: What is the role of the NIOSH (or other elements of CDC) in evaluating and/or issuing standards for personal protective equipment that could be used in responding to a real or suspected terrorist incident involving biological, chemical, radiological, or nuclear threats?

Dr. Gerberding: NIOSH established the National Personal Protective Technology Laboratory (NPPTL) in Pittsburgh to support the long-term development of standards and technologies to protect the health and safety of American workers who rely on personal protective equipment. Activities of NPPTL include the testing and qualification of chemical, biological, radiological, and nuclear (CBRN) respirators to meet NIOSH approval requirements; audits of product and manufacturing site; and enhancements to the NIOSH respirator certification programs and laboratories. Related activities include respirator certification, quality assurance audits, health hazard evaluations, providing technical assistance, enhancing laboratory capabilities and qualifications, and coordinating support services among federal and private sector organizations to achieve these objectives. Additionally, NIOSH supports counter-terrorism and national preparedness by working to expeditiously incorporate technological advancements into national consensus standards.

In addition to NIOSH's work developing upgraded standards, user guidelines and certification programs for a number of CBRN respirator types (e.g. powered air-purifying respirators, escape hoods, combination supplied-air/air-purifying respirators, etc.), NIOSH also is actively pursuing research related to effectiveness of fit-testing methods for various respirator classes, particulate filter efficiency degradation assessments, decontamination studies of impacts on protective capacities of gloves, service life indicators for clothing and respirator cartridges, and chemical hazards classifications, all necessary to develop appropriate standards to protect emergency responders.

Mr. Obey: What activities has CDC undertaken in this area and what have been the results?

Dr. Gerberding: In December 2001, CDC finalized a respirator certification standard for full facepiece self-contained (compressed air) breathing apparatus (SCBA) for use against CBRN agents. Since then, twelve CDC-approved models of CBRN SCBA (identified under nine CDC approval numbers) have become available to responders for use in counter-terrorism response. Recognizing that many responders already have older SCBA units that do not meet the new standards, CDC developed and implemented a program for manufacturers so that they can upgrade existing equipment to meet the new CBRN approval standards. Additional approval applications continue to be processed, and approval of additional models is progressing.

In March 2003, CDC finalized a respirator certification standard for full facepiece air purifying (gas mask) respirators (APR) for use against CBRN agents. CDC expects issuance of approvals for conforming models to begin in the Fall of 2003. CDC is continuing to develop standards for other types of respirators on a priority basis and is developing a respirator certification standard for CBRN escape respirators as the next priority.

Additional CDC activities in evaluating and/or issuing standards for personal protective equipment for use in responding to terrorist incidents include the following:

CDC is collaborating with the U.S. Army Soldier, Biological, Chemical Command on a program to: develop guidelines for the selection, use, maintenance, care and decontamination of CBRN certified respirator; and to identify alternatives for chemical warfare agents to be used for design, manufacture and research in the area of CBRN respirator technologies.

CDC representatives are active participants in the standards setting process of the National Fire Protection Association (NFPA) which is involved with responder issues relative to personal protective equipment. CDC is conducting a project to evaluate Health and Safety Guidelines for Emergency Workers: Post-Structural Collapse Hazards. The project is being conducted in conjunction with other federal agencies and interested stakeholders.

Mr. Obey: Roughly how much did CDC spend on these activities in FY 2002, and how much do you anticipate spending in FY 2003 and FY 2004?

Dr. Gerberding: CDC spent \$9.1 million of its base occupational safety and health dollars on these efforts in FY02 and estimates spending \$8.8 million in FY03 and \$8.8 million in FY04.

In FY02, as a result of the World Trade Center (WTC) and anthrax emergencies, CDC was allocated approximately \$2.2 million in FY02 and \$1.2 million in FY03 for standards development activities. CDC will request funding at the same level in FY 04 (\$1.2 million). In September 2002, CDC received a one-time allocation, also related to the WTC and anthrax emergencies, to support standards development for CBRN respirators and related activities. The funds were appropriated as "no year" dollars and we estimate that \$4.5 million will be spent in FY03 and \$2.7 million will be spent in FY04.

The following provides a summary of the total dollars described above:

FY02: \$11.3 million
 FY03: \$14.5 million
 FY04: \$12.7 million

Mr. Obey: Of the amounts appropriated for the HRSA Hospital Preparedness program in FY 2002 and FY 2003 and requested for FY 2004, what portion was distributed (or will be distributed) to states and localities under the basic cooperative agreements and what portion will be used for other purposes (such as technical assistance and evaluations)? Please also indicate the nature of any uses of these funds apart from distribution under the cooperative agreements.

Dr. Duke: Out of a total of \$135 million available in FY 2002, \$125.1 million (93%) was allocated to cooperative agreements to states, cities and territories. The remainder was budgeted for program operating expenses (\$1.4 million or 1%), contracts to technical assistance and professional organizations in support of state and local activities (\$3.5 million or 2.6%), research efforts through an interagency agreement with AHRQ (\$3 million or 2.2%), and evaluation of bioterrorism preparedness at the hospital level (\$2 million or 1.5%).

Out of a total of \$514.6 million available in FY 2003, \$498 million (96.8%) will be allocated to cooperative agreements. The remainder is tentatively budgeted for program operating expenses (\$1.8 million or 0.3%), contracts to technical assistance and professional organizations in support of state and local activities (\$2.15 million or 0.4%), contracts to develop a national incident command system, a national hospital syndromic surveillance system, and training activities (\$1.85 million or 0.4%), and general program evaluation (\$10.8 million or 2.1%). Proposed funding for FY 2004 will follow a similar pattern.

Mr. Obey: What specific formula was used to allocate funds among the various states, territories, and large cities under the HRSA Hospital Preparedness program in FY 2002?

Dr. Duke: All states, Puerto Rico, New York City, Chicago and Los Angeles County received a base amount of \$250,000 (Washington, DC received a base amount of \$500,000) plus an amount based on their population divided by the national population. The Virgin Islands, Guam, the Northern Marianas and American Samoa each received \$150,000 without an additional population-based amount.

Mr. Obey: Do you anticipate changing that formula (or the dollar amounts used in the formula) in FY 2003 and/or FY 2004? If so, how?

Dr. Duke: In FY 2003, the baseline amount for all jurisdictions other than Washington, DC and the four territories will be \$1,000,000. The baseline for Washington, DC will be \$2,000,000. The four territories and the three new grantees (Palau, Micronesia and the Marshall Islands) will each receive a \$500,000 base. All jurisdictions will now receive a population-based amount in addition.

Mr. Obey: What do you consider to be the specific provisions of authorizing law governing or guiding the allocation and use of the funds under the HRSA Hospital Preparedness program?

Dr. Duke: The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107-188) authorizes Section 319-C of the Public Health Service Act (42 U.S.C. 201 et seq.), which supports activities related to countering potential terrorist threats to civilian populations. Funding was provided under the 2003 Consolidated Appropriations Resolution (Public Law 108-7).

Mr. Obey: What benchmarks has the Department of HHS set for assessing the adequacy of hospital preparedness to respond to a terrorist incident, other mass casualty event, or major epidemic?

Dr. Duke: For the FY 2002 program guidance, HRSA included three critical benchmarks. These focused on assuring program direction, establishing a Hospital Preparedness Planning Committee, and developing Regional Hospital Plans to deal with a potential epidemic involving at least 500 patients in each State or region. HRSA is currently preparing the guidance for the FY 2003 Hospital Preparedness Program. Provided below are examples of the types of benchmarks that we expect to include.

- Establish a system that allows the triage, treatment and disposition of at least 500 adult and pediatric patients per 1,000,000 population with acute illness or trauma requiring hospitalization from a biological, chemical, radiological or explosive terrorist incident.
- Upgrade or maintain airborne infectious disease isolation capacity to have at least one negative pressure, HEPA-filtered isolation facility per awardee, to be placed in accord with the findings of the awardee's needs assessments. Such facilities must be able to support the initial evaluation and treatment of 10 patients at a time having a clinical contagious syndrome suggestive of smallpox, plague or hemorrhagic fever, prior to movement to a definitive isolation facility.
- Establish a response system that allows the immediate deployment of 100 or more extra health care personnel per 1,000,000 population in urban areas, and 50 or more health care personnel per 1,000,000 of population in rural areas.
- Develop a system that allows the credentialing and supervision of clinicians not normally working in facilities responding to a terrorist incident.
- Establish a response system that allows the triage, treatment and disposition of 10,000 asymptomatic adult and pediatric patients per 1,000,000 population with exposure to an infectious disease or radiological source requiring medication prophylaxis or immunization within the first four days of a terrorist incident.

- Ensure adequate personal protective equipment to protect 100 or more extra personnel per 1,000,000 of population in urban areas, and 50 or more personnel per 1,000,000 of population in rural areas, during a biological, chemical or radiological threat.
- Ensure that adequate portable or fixed decontamination systems exist for managing 500 patients and health care workers per million population, who have been exposed to biological, chemical or radiological threats.
- Establish a system that allows the provision of short and long-term mental health services to 5,000 adult and pediatric clients and health care workers per 1,000,000 population exposed to a biological chemical, radiological or explosive terrorist incident.
- Develop a mutual aid plan for upgrading and deploying EMS units in jurisdictions they do not normally cover, in response to a mass casualty incident due to terrorism. This plan must ensure the capability of providing EMS coverage for at least 500 patients per million of population per day.
- Implement a hospital laboratory program that is coordinated with currently funded CDC laboratory capacity efforts, and which provides rapid and effective hospital laboratory services responding to terrorism and other public health emergencies.
- Enhance the capability of rural and urban hospitals, clinics, emergency medical services systems and poison control centers to report syndromic and diagnostic data that is suggestive of terrorism to their associated local and state health departments on a 24-hour-a-day, 7-day-a-week basis.
- As part of a written evaluation strategy of the awardee's program, conduct at least one bioterrorism disaster exercise in the jurisdiction during FY 2003 that covers a large-scale epidemic scenario.

Mr. Obey: What is your estimate of the current state of preparedness relative to those benchmarks?

Dr. Duke: The program has collected data from information provided by grantees in their 2002 applications and their November 2002 semi-annual report. The significant findings are summarized below:

Regional Hospital Plans

- 59% of grantees reportedly have planned for a potential epidemic involving at least 500 patients in the State or region.

- 75% of the grantees included a timeline that describes the approach to development and implementation of the regional hospital plan for large-scale epidemics in their application.
- 58% of plans describe increasing hospital bed capacity to accommodate increases in admissions from an infectious disease epidemic over an extended period of time.

Medications and Vaccines

- 95% of plans describe the State health department readiness plan for immediate receipt and distribution of antibiotics and smallpox vaccines made available from Federal sources.

Communications

- 72% of plans address gaps in the communications systems among hospital emergency departments, outpatient facilities, EMS systems and State and local emergency management, public health and law enforcement agencies, as they relate to bioterrorism response.

Personal Protection, Quarantine, and Decontamination

- 56% of plans describe how existing decontamination systems will be upgraded to allow for large numbers of patients exposed to particulate infectious material from an airborne or environmental release (such as fixed hospital units, portable units, or Disaster Medical Assistance Teams (DMATs) capable of mobile decontamination).

Evaluation efforts are currently being undertaken to more fully answer these questions. One is a hospital preparedness survey being developed by the Agency for Healthcare Research and Quality (AHRQ), under an intra-agency agreement with HRSA. This will be designed to be used in subsequent cooperative agreement applications. Additional evaluation tools are under development

COUNTERMEASURES AGAINST BIOTERRORISM

Mr. Obey: How do you envision the process of development of vaccines, therapeutics and other countermeasures against bioterrorism proceeding from concept to production and approval or licensing? In particular, what do you see as the role of NIH at the various stages of this process and what do you see as the role of the private sector? How does this differ from the usual process of development of new drugs or vaccines?

Dr. Fauci: The pathway from idea to final product for all products, whether it be for countermeasures against bioterrorism or a naturally occurring disease, is equally complex. The optimal scientific approach to identifying the best drug and vaccine candidates must be based on laboratory studies. Testing must be performed in appropriate animal models to document safety and appropriate protective or treatment response, and to help determine dosing. Human studies must be carefully initiated to

assure the basic safety of the product, and then appropriate dosing and response must be determined based on measurements of levels of drug or antibody predicted to have a protective effect. Steps must be taken to assure that the materials used to make the countermeasures ---and the final product itself--- can be manufactured safely, free of contaminants, and with reproducible and predictable purity, potency, and composition. Careful trials in humans, or where not possible, animal models, must be performed to show that the product is safe and effective for the types of populations which might receive it and against the methods of infection or exposure that could be encountered. All of these steps require careful planning, experience, and ongoing management and scientific evaluation.

The process of moving from concept to production and licensing for the development of vaccines, therapeutics and other countermeasures against bioterrorism is a public and private partnership. Investment by the private sector in the development of biodefense products is essential but remains limited. The interaction of industry or non-profit organizations with the government is strongly encouraged to quickly transition candidate products through pre-clinical development and clinical testing and commercialization.

Traditionally, NIH plays a large role in the early stages of product development, including basic biology and target identification. As the process moves through pre-clinical development, NIH often works with private sector partners, with the idea that ultimately the private sector partner will become responsible for the final stages of development and testing. For biodefense, NIH has developed funding mechanisms that provide support for projects as they move through later stages of product development, including product validation, scale-up, and Phase I and/or Phase II clinical trials.

One important difference is the lack of a guaranteed commercial market for some of the preventions or treatments that are being developed for countermeasures for potential agents of terrorism, and hence the lack of corporate-initiated interest. NIH has developed several mechanisms to help support product development in these areas through cost sharing of product development with industry. This fiscal year, NIH announced several initiatives to encourage partnerships with private industry, including ABiodefense Partnerships@ and ACooperative Research for the Development of Vaccines, Adjuvants, Therapeutics, Immunotherapeutics, and Diagnostics for Biodefense.@ NIH has also awarded contracts to companies to further the development of anthrax and smallpox vaccines.

Costs to develop and manufacture high quality biological products and perform and evaluate the needed animal and human studies are high. Grants and contract mechanisms may not always be sufficient or attract the most experienced manufacturers. Manufacturing capacity for biological products, particularly for vaccines, is not substantial. For all these reasons, the best possible support and public-private partnerships and teamwork are essential.

Mr. Obey: What process has been followed (as far as the roles of the various participants) in developing the next generation anthrax vaccine that NIH has been working on? To what extent would you consider this a model for development of other bioterrorism countermeasures?

Dr. Fauci: For the past four years, NIH and U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID) have been working closely on the development and pre-clinical testing of a recombinant protective antigen (rPA) vaccine for anthrax. NIH supports USAMRIID research efforts for this lead vaccine candidate through an Inter-agency agreement. It is anticipated that Phase I/II clinical trials of the USAMRIID rPA vaccine will begin soon. These clinical trials will be conducted through NIAID's Vaccine and Treatment Evaluation Unit contracts.

In addition, NIH has awarded contracts to two companies, Avecia and Vaxgen Inc., to accelerate the development of second generation anthrax rPA vaccines. The companies' challenge will be to take this experimental vaccine strategy through several stages of development, including manufacturing pilot lots of the vaccine, testing for safety in laboratory and clinical trials, testing for efficacy in animals, and preparing and submitting all necessary Food and Drug Administration (FDA) applications. Each company will also submit a feasibility plan to manufacture, test, secure FDA approval for, and deliver to the government up to 25 million doses of its vaccine.

NIH also funds multiple grants that focus on the development of novel anthrax vaccines and vaccine delivery systems. The research conducted through these grants will contribute to the development of improved anthrax vaccine strategies for the future.

The development of next generation anthrax vaccines is a model in that NIH has dedicated resources and expertise, and has partnered with other government agencies and the private sector as necessary to pursue and accelerate the development of an important bioterrorism countermeasure. One key distinction is that a candidate was available for rapidly moving forward with development. For other agents, more basic research may be needed to identify potential candidates.

ANTHRAX VACCINE

Mr. Obey: Does NIH intend to use any funds for procurement of anthrax vaccine during FY 2003 or during FY 2004?

Dr. Fauci: The NIH has accelerated efforts in FY 2003 towards the identification and development of multiple "recombinant protective antigen" (rPA) candidate Anthrax vaccines, in accordance with the Bush Administration's strategy against bioterrorism. We expect to have developed IND material in early 2004.

EXTRAMURAL FACILITIES CONSTRUCTION

Mr. Obey: How many extramural facilities construction grants for bioterrorism preparedness do you expect to award in FY 2003 and what do you expect will be the total amount of funding provided? How many facilities of various types are these grants expected to support?

Dr. Fauci: In FY 2003, NIAID expects to make two National Biocontainment Laboratory (NBL) awards and between three to six Regional Biocontainment Laboratory (RBL) awards. The NBL awards are each expected to be for \$100-150 million dollars and the RBL awards are each expected to be between \$25 to 40 million dollars, for a total of approximately \$372 million dollars in construction awards.

Mr. Obey: Do you anticipate providing an extramural facilities construction grant to each of the new extramural Centers of Excellence for Biodefense and Emerging Infectious Diseases?

Dr. Fauci: The Regional Centers of Excellence for Biodefense and Emerging Infectious Diseases (RCEs) and the NBLs and RBLs are designed to be complementary and part of a nationwide network of biodefense research infrastructure.

Mr. Obey: Why are no funds requested for additional bioterrorism-related extramural facilities grants in FY 2004? Do you believe that FY 2003 funding will be sufficient to meet the needs for assistance with construction of the BSL-3 and BSL-4 laboratories needed for the greatly expanded research programs envisioned in the NIH budget?

Dr. Fauci: The NIH strategic plan for biodefense provided funding for the first phase of construction in fiscal years 2003 and 2004. However, the research community has responded quicker and more broadly than anyone expected to the challenge of building these specialized, high-containment labs which are necessary to conduct research on these pathogens. Due to the urgent need to rapidly build and make available these specialized research labs to extramural scientists, we decided to take advantage of this emerging opportunity and to accelerate the construction process by funding the entire first phase in FY 2003. The amount of funds originally identified for the construction of the specialized extramural labs in the biodefense long-range plan for FY 2004 will now be used to fund research deferred from FY 2003, thus providing a balanced approach to addressing both construction and research needs for biodefense in the first two years of the ramp-up.

We believe that the extramural construction budget contained in the FY 2003 Amended President's Budget is sufficient to meet the initial requirements. The budgets in FY 2003 and 2004 provide for a balanced approach to address both construction and research needs.

Mr. Obey: How are decisions being made about allocation of research resources among the various biological agents that could be used for bioterrorism? To what extent are these decisions driven by the subject matter chosen by applicants for investigator-initiated research grants and the results of the peer review process, and to what extent is NIH trying to direct research efforts toward particular areas and stimulate proposals involving specific agents?

Dr. Fauci: Since the fall of 2001, the NIH has moved quickly to accelerate basic and clinical research related to the prevention, diagnosis and treatment of diseases caused by potential agents of bioterrorism. In fiscal year 2002, these efforts focused on the "Category A" agents, including the pathogens that cause anthrax, smallpox, plague, botulism, tularemia, and viral hemorrhagic fevers. NIH developed a Strategic Plan for Biodefense Research, as well as a detailed Biodefense Research Agenda for CDC Category A Agents, with short-, intermediate-, and long-term goals. As part of the strategic planning process, NIH brought together many of the Nation's top experts for a Blue Ribbon Panel on Bioterrorism and its Implications for Medical Research to assess the current state of research related to bioterrorism and make recommendations regarding priorities and implementation. The Strategic Plan and Research Agenda stress two over-arching and complementary components: basic research into agents with bioterrorism potential and the specific and non-specific host defense mechanisms against those agents; and applied research with pre-determined milestones for the development of new or improved diagnostics, vaccines and therapies

In October 2003, NIH convened another Blue Ribbon panel of experts to provide objective recommendations on NIH's research agenda for Category B and C priority pathogens, including short-, intermediate-, and long-term goals for research on this expanded list of pathogens.

To ensure the quality of the research, applications for support from the NIH go through the traditional two-tiered peer review process. Applications are evaluated initially by peer review groups composed of scientists from the extramural research community. The objective of the initial peer review is to evaluate and rate the scientific and technical merit of the proposed research or research training. The second level of peer review is carried out by the NIH National Advisory Councils. Composed of scientists from the extramural research community and public representatives, these Councils make funding recommendations based both on scientific merit and on the relevance of the proposed study to the Institute's programs and priorities.

A primary objective of NIH's biodefense research program is to attract the long-term interest and support of industry and academia in the efforts needed to develop effective bioterrorism countermeasures. Due to the recent increased emphasis on biodefense research, NIH has developed several Requests for Applications (RFAs) and Requests for Proposals (RFPs) during the past two years with set aside dollars to attract scientists to this area of research. In 2002 and 2003, NIAID developed a total of 52 biodefense initiatives to stimulate research; 36 are new initiatives and 16 are significant

expansions. During this same time period, NIAID has seen a 30 percent increase in the number of grant applications -- the vast majority of these are in response to our biodefense initiatives.

In Fiscal Year 2002, several NIAID initiatives encouraged industry partnerships and focused on the development of new diagnostics, vaccines and therapeutics for CDC Category A agents. These types of research initiatives have been well received. As a result, NIAID has expanded and reissued many of these collaborative efforts in Fiscal Year 2003, and we plan to do the same in Fiscal Year 2004. In addition, the new initiatives have been broadened to address NIAID's Category B and C Priority Pathogens and are responsive to the recommendations included in our Category B and C research agenda.

Most of this expansion has been pursued through RFAs, which require scientists to initiate the development of grant applications that are then submitted through the traditional peer review process. While the RFAs, in general, broadly define the parameters of requested research, investigators have considerable leeway in designing the scope and approach of their investigation. For circumstances that require the development of very specific products, NIAID has issued RFPs, which outline the specific tasks to be completed and are awarded as contracts. Some examples of recent biodefense RFPs include ADevelopment and Testing of Vaccines Against Anthrax@ and ADevelopment and Testing of a Modified Vaccinia Ankara (MVA) Vaccine.@

Mr. Obey: More generally, to what extent does NIH plan to rely on investigator-initiated research project grants in its bioterrorism research programs and to what extent does NIH plan to solicit proposals in particular subject areas or rely on research and development contracts? How does this differ from the general NIH portfolio?

Dr. Fauci: Investigator-initiated research has and will continue to be the foundation of research at NIAID. However, because of the public health importance, and the unique issues related to rapid development of countermeasures to protect the public, biodefense is not business as usual. Therefore, in addition to maintaining our strong commitment to high quality investigator-initiated research, NIAID has increased the use of directed research and development contracts to fund advanced development of biodefense products. These contracts include milestones and performance measures. Important examples of product development contracts include "Development and Testing of Vaccines Against Anthrax" and "Development and Testing of a Modified Vaccinia Ankara (MVA) Vaccine."

Proportionally, the NIH as a whole allocates less money for contracts than NIAID. NIAID's proportionally larger allocation is in large part due to the fact that biodefense contract dollars are supporting expansion of clinical trial infrastructure to enable studies of the next generation biodefense vaccines and therapeutic agents, to establish repositories for biodefense diagnostics and drug reagents, to develop animal models, to support specialized studies, and to establish and expand a library of databases

containing genomic sequences and proteomic analyses of pathogens that are potential bioterror agents. In addition, the research project grant pool comprises a somewhat smaller proportion of NIAID's budget than NIH as a whole. However, this is really an aberrancy peculiar to this year, since NIAID usually has a much greater proportion of its budget in research project grants.

Mr. Obey: What work is NIH undertaking or planning that is aimed at improving countermeasures against chemical, rather than biological, threat agents?

Dr. Fauci: NIH has recognized that biological threats are not the only terrorist threats facing this nation. In March 2003, NIAID convened an expert group of scientists to determine where scientific gaps existed that were critical in the development of chemical countermeasures. It was recognized that the chemical dangers involved both chemical warfare agents and industrial chemicals, and that many of the countermeasures that had been developed by the military had limited applicability in the civilian setting. Civilian research needs and products that could be adapted and studied for use in broader populations were discussed.

An effort is currently underway to have NIH engage in research that will address the nation's needs. Such areas include the development of anticonvulsants and new antidotes against nerve agents and improvements in therapeutic interventions against vesicating blister agents and pulmonary choking agents. In addition, a basic understanding of mechanisms of action and the host response to specific agents is critical for developing effective antidotes and therapeutics.

Mr. Obey: Finally, I'd like to ask about the "BioShield" proposal. According to the Administration's proposed legislation, in order for a countermeasure to be eligible for funding under the BioShield program it must have been approved or licensed by the FDA, or the Secretary of HHS must determine "that sufficient and satisfactory clinical experience or research data ... support a reasonable conclusion that the product will qualify for approval or licensing as such a countermeasure within five years". Doesn't this require considerable research, development and testing to have already been completed on a possible new drug or vaccine before a BioShield contract can even be signed? Do you believe that private firms will undertake this work before they have a BioShield contract in hand? Or do you envision funding being provided by NIH or another government agency for the work needed to bring a product to the point where it becomes eligible for Bioshield?

Dr. Fauci: Yes; the need to show that new drugs and vaccines are both safe and effective remains paramount under Project BioShield, as it has been proposed. In the interest of national security and public health, it is essential that the Department, through FDA, engage in the process as early as possible with sponsors and organizations that are developing the therapeutics, vaccines, and rapid diagnostics. The Department will maintain a proactive role to help ensure that the products are developed as efficiently as possible.

We hope that will be the case. Working with the Department, CDC, and NIH, FDA has already identified several products that would likely qualify as countermeasures and is meeting with sponsors to help foster the successful development of such products. The research and development support for such countermeasures, provided by NIAID, should also help to encourage corporate interest.

NIH currently has many mechanisms in place for assisting companies with product development, and we intend to keep working with companies to help them bring new products to the market. For example, NIAID awarded six Partnership Grants in fiscal year 2002 to support collaborative partnerships between government, academia, and the private sector to develop novel biodefense products. The fiscal year 2003 Biodefense Partnerships Initiative continues this important work by supporting all phases of development of a candidate product or platform technology, including but not limited to early validation, pre-clinical stages, scale-up, production, regulatory requirements, and, where appropriate, clinical or field evaluation. NIAID also is supporting the Cooperative Research for the Development of Vaccines, Adjuvants, Therapeutics, Immunotherapeutics, and Diagnostics for Biodefense program. Research conducted through this program may fall anywhere along a broad spectrum of activities, from target identification, design of compounds, validation and testing, production scale-up and validation, through advanced preclinical evaluation. NIAID plans to renew this initiative in the near future. In addition, the NIH Small Business Biodefense Program allows for expanded duration and dollar amounts for Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) applications with a biodefense research focus. NIAID is also working to expand research resources. All of these initiatives will continue to help companies develop new products that may eventually be eligible for purchase under Project BioShield.

PUBLIC HEALTH SYSTEM

Mrs. Lowey: The public health system cannot work unless there are enough trained professionals to deal with these issues. The anthrax outbreak in New York City provides a perfect example of how far our system is currently stretched. Tens of thousands of scared New Yorkers flooded into emergency rooms, doctors' offices, community health centers, even police and fire stations, to be tested for anthrax exposure. The New York City and State public health laboratories were so swamped with items to be tested that lab workers slept at the lab for a week. Clearly, we will need more qualified and trained personnel available to deal with a large outbreak.

Yet, the Administration's budget calls for a \$297.5 million cut in health professions programs, which helps to recruit and train nurses and allied health professionals. The corresponding \$41.8 million increase for the National Health Service Corps is simply not enough to make up for this cut. There is also a nursing shortage in the United States that shows no sign of abating. We are short on lab technicians and other medical personnel. Can you explain to the subcommittee how hospitals and public health officials will be able to deal with a bioterrorism event with a shortage of trained personnel?

Dr. Duke: The Bioterrorism Training and Curriculum Development Program, funded at \$28 million in FY 2003 and proposed for \$60 million in the President's FY 2004 budget, will equip a workforce of healthcare professionals to address the medical consequences of bioterrorism and other public health emergency preparedness and response issues. In this context, "other public health emergencies" includes other forms of terrorism (such as use of chemical, explosive, incendiary, or nuclear agents against the civilian population) as well as natural disasters and catastrophic accidents. Specifically, the goal of this program is the development of a healthcare workforce that possesses the knowledge, skills and abilities to: (1) recognize indications of a terrorist event; (2) meet the acute care needs of patients, including pediatric and other vulnerable populations, in a safe and appropriate manner; (3) participate in a coordinated, multidisciplinary response to terrorist events and other public health emergencies; and (4) rapidly and effectively alert the public health system of such an event at the community, state, and national level. This training focuses on two populations of providers: (a) the practicing providers thorough continuing education; and (b) those in training programs through curricular enhancement. Within the first year of this program 38,000 providers are targeted for training including allied health, nursing, medicine, nurse practitioners, physician assistants, dentists, pharmacists, mental health providers and others such as EMS personnel and veterinarians.

Mrs. Lowey: Under the Public Health Security and Bioterrorism Preparedness and Response Act, the Secretary of Health and Human Services has the authority to designate high risk areas and give priority to these areas when distributing bioterrorist preparedness funding based. As you know, New York City is considered the number one terrorist target and is mentioned in approximately 80% of the tips received by

intelligence sources. Given NYC's vulnerability to a terrorist attack, unique size and population density, and large underserved population, has HHS considered assigning New York City a special designation? When will HHS be making these decisions?

Mr. Hauer: The Public Health Security and Bioterrorism Preparedness and Response Act, PL 107-188, passed June 12, 2002, states in Sec. 319C-1.(b)(1)(a)(B)(i) that the Secretary may make awards to such entities as "a political subdivision of a State or a consortium of 2 or more such subdivisions" provided that they prepare and submit an application and information in such a manner as the Secretary requires and that it is in coordination with and consistent with applicable Statewide plans. Additionally, under Sec. 319C-1. (j)(4)(A), the Secretary can award up to three political subdivisions that "have a substantial number of residents, have a substantial local infrastructure for responding to public health emergencies, and face a high degree of risk from bioterrorist attacks or other public health emergencies." Based on these provisions, HHS deemed New York City eligible for direct bioterrorism preparedness funding. In FY 2002 New York City received its own cooperative agreement award from both CDC and HRSA and will be likewise funded in FY 2003.

HHS recognizes that New York City has suffered from acts of terrorism, similar to Washington, DC and Oklahoma City, and has a high risk profile. Consequently, along with Chicago and Los Angeles County, its award is based on the same funding formula as that used to compute allocations for the states. This decision by the Secretary of Health and Human Services demonstrates our commitment to provide additional assistance to New York City.

For FY03, New York City has been allocated \$33,740,099. Eighty percent of the remaining awardees received allocations smaller than that of New York City. A funding chart may be found on the HHS website at <http://www.hhs.gov/news/press/2003pres/20030320.html>.

Mrs. Lowey: The Public Health Security and Bioterrorism Preparedness and Response Act also recommended that an official Federal Internet site on bioterrorism be established. I realize the Centers for Disease Control, Department of Homeland Security, and others have timely, accurate, and relevant emergency preparedness information on their web pages, but has one specific site been posted to provide this information to the public?

Mr. Hauer: The Department of Health and Human Services (HHS) and the Department of Homeland Security (DHS) have signed a Memorandum of Agreement (MOA) that includes, among other things, the development of a common portal through which States and other jurisdictions can access information on various federal programs on preparedness for and response to bioterrorism and other public health emergencies. This portal, to be developed in collaboration with other federal agencies as well, is intended to provide an easily accessible website for the public that provides information on the entire range of relevant activities supported or conducted by the Federal government.

SMALLPOX VACCINATION

Ms. DeLauro: I want to ask a question about the effort to vaccinate emergency personnel against smallpox. As you know, my state of Connecticut was the first state to implement the smallpox vaccination plan, but has found that many doctors and nurses have refused the vaccination due to their concerns about a lack of compensation should they experience any adverse side effects. I think these fears were in part vindicated by the CDC's announcement that no one with a history of heart disease should receive the smallpox vaccination -- an announcement that came after seven vaccine recipients got very ill, one is on life support, and another actually passed away. As you know the House was to consider legislation on the issue of compensation today, however we could not reach an agreement and the bill was pulled. Hopefully we will take action soon to make sure these people and their families receive adequate compensation for what is in effect a workplace-related injury. Can you update us on how the vaccination plan is proceeding?

Dr. Gerberding: The goal of smallpox preparedness is to ensure federal, state, and local health agencies have optimal capacity to respond to a smallpox outbreak. In FY 2003, CDC issued smallpox preparedness program guidance for those states and other jurisdictions receiving funds through CDC's bioterrorism cooperative agreement, for both post-event (or post-attack) and pre-event preparedness activities. In addition, CDC has been working with the IOM to help advise us on implementation. The pre-event activities focused on implementing the smallpox civilian vaccination program. As of April 18, 2003, 33,644 public health and health care workers have received smallpox vaccine through this program. One thousand seven hundred ninety-three hospitals, 36% of the nation's acute care hospitals, have had at least one staff member vaccinated.

Ms. DeLauro: Should we be worried that so few people have elected to receive the vaccination?

Dr. Gerberding: The smallpox vaccination program is part of overall preparedness for a smallpox outbreak. As the program has evolved, fewer persons have been vaccinated than some expected because states and local areas have better defined their measures of preparedness to manage a smallpox outbreak. CDC will be publishing the lessons learned from the more successful areas in the MMWR and will issue guidance for states and local areas receiving preparedness funds that will further define preparedness measures for a smallpox outbreak.

Ms. DeLauro: Can you assure people that the vaccine is truly safe?

Dr. Gerberding: Smallpox vaccine is very safe for the vast majority of people receiving it. These vaccinees may suffer local pain, swollen lymph nodes, fever, or other mild symptoms. CDC expected that a small number of persons would suffer from serious or life-threatening adverse events that had been previously associated with the vaccine, with a range of 14 to 52 per million persons vaccinated for the first time.

Two issues have surfaced related to the recently identified cardiac events after vaccination:

Myo-pericarditis (or inflammation of the heart and/or the sac lining it) was not clearly associated with the current vaccine in the past, though it had been associated with other countries' smallpox vaccines. There are no risk factors that one can use to identify persons likely to develop this syndrome. To date, seven persons with this condition have been identified following vaccination in the civilian program, and all are doing well.

The ischemic heart illnesses (angina and myocardial infarction, or heart attack) have never been proven to be associated with smallpox vaccine. The rate of death from heart attack in the vaccinated persons to date is no different than that expected rate in unvaccinated persons. CDC is working aggressively to study the association to see if the vaccine may have caused or precipitated any of these illnesses or deaths. As a precaution, CDC has recommended restricting use of the smallpox vaccine to persons without heart disease and/or risk factors for heart attack.

Ms. DeLauro: Dr. Gerberding, as you know, CDC and the states have encountered significant challenges in implementing the Smallpox Vaccination Program. A central issue is the fear on the part of many members of the public, including health care workers, that the risk of side effects from the vaccine is not worth the risk considering the lack of an imminent threat of a smallpox outbreak. This is an example of how people's desire for as much information as possible about the risks and benefits of inoculation against bioterror threats will help determine the success of these programs.

I understand that there are advanced technologies available that can use genomic information to develop diagnostics that may provide more of that information to individuals. For example, there is a bio-tech company in my district -- Genaissance Pharmaceuticals -- that utilizes a diagnostic to identify those individuals who should either avoid vaccination or receive lower doses of the vaccine because they develop immunity readily when inoculated. I would assume that successful diagnostics would be an aid to the Smallpox Vaccination Program and future anti-bioterrorism vaccination programs, is that correct? Is there an office or division at CDC who would be responsible for considering such technologies?

Dr. Gerberding: It is possible that improved diagnostics might certainly aid this and other activities. The Food and Drug Administration's Center for Devices and Radiological Health has responsibility for guaranteeing the safety and reliability of diagnostic tools.

FOOD SAFETY/BIOTERRORISM

Ms. DeLauro: A couple of weeks ago, Secretary Ridge announced the creation of Operation Liberty Shield, a plan to increase security for the homeland. Along with a variety of other efforts, the Secretary mentioned food safety as part of this plan. Specifically, he mentioned that there will be "greater inspection of imported food" and that food security will be part of this coordinated, national plan. Is FDA part of Operation Liberty Shield? How are you contributing to the plan?

Dr. McClellan: Operation Liberty Shield is a comprehensive national plan designed to increase protections for America's citizens and infrastructure while maintaining the free flow of goods and people across our border with minimal disruption to our economy and way of life. The Department of Health and Human Services has many critical roles in this multi-department, multi-agency, national team effort.

With responsibility for the safety and security of 80 percent of the nation's food supply, the Food and Drug Administration has initiated the following new activities: working with the food industry to reduce threats -- FDA has issued new industry guidance on security measures, and has encouraged specific additional industry security measures in response to the increased threat level; increased surveillance of the domestic food industry -- FDA has increased facility inspections and product sampling; increased monitoring of imported foods -- FDA has increased examinations and sampling of imported foods; and, enhanced collaboration with other government agencies -- FDA has increased its joint activities with Federal, state, and local partners to help ensure a safe and secure food supply, including work with CDC to ensure that outbreaks of illness or unusual patterns of illness or injury are quickly investigated.

FDA's new Liberty Shield initiatives build on HHS Secretary Thompson's leadership on food security, including: developing new regulations and guidance documents to enhance import security and contain outbreaks of foodborne illness; hiring over 800 new inspectors and field personnel; building greater laboratory testing and response capabilities; and using intelligence information to help guide food security activities.

The guidance documents developed as part of the government-wide Liberty Shield initiative cover each segment of food and cosmetic operations, focusing on practical steps that will improve safety and security. Two of the guidances are revised final documents, and two are proposed guidances. The final documents will help operators of food establishments, such as firms that produce, process, store, repack, re-label, distribute, or transport food or food ingredients, and operators of food importing establishments, storage warehouses, and customs brokers identify preventive measures improve the security of their operations. The proposed guidances cover food stores and food service establishments such as bakeries, bars, cafeterias, commissaries, convenience stores, fairs, grocery stores, food service for airlines and trains, restaurants, and vending machine operators as well as cosmetic establishments. They also identify preventive measures that operators can to minimize the security risks to their products.

FDA's guidance documents are not regulations and are not mandatory. They set forth voluntary recommendations from FDA. They do not create or confer any rights for, or on, any person and do not operate to bind FDA or the public. FDA has found that developing guidance is the fastest way to get these types of recommendations to the industry, while allowing greater flexibility to alter recommendations as science and intelligence information changes. In matters such as these, industry generally follows FDA's recommendations.

Ms. DeLauro: My understanding is that FDA currently is only able to inspect a little over 1 % of imported foods, even with the additional inspectors you received from the FY 2002 supplemental. What percentage of food imports are you able to inspect? Do you have the necessary resources to protect the public health? How will you comply with Secretary Ridge's call to have greater inspection of imported foods?

Dr. McClellan: Ensuring the safety of imported foods is a priority of the highest magnitude. However, FDA is reaching its resource capacity to handle this demand, both in terms of funding and human capital. With the FY 2002 supplemental, FDA was able to hire and train over 800 field personnel including investigators for border locations where FDA receives significant amounts of regulatory products. The Agency is currently evaluating the public health consequences, or risk, of product-agent-activity combinations associated with tampering and/or terrorist activity. The evaluation of this information will be used allocate resources to minimize risk to the U.S. public.

The information will be used to reassess priorities for: domestic and foreign inspections; inspection coverage of importers; and, import sampling and/or field examinations. FDA plans to share this information, to the extent appropriate, with state and foreign governments and industry, and is also assessing our ability to respond to high-risk product-agent scenarios. This includes a review of our current scientific capabilities that may be available for extramural sources such as academia and the Department of Defense, and evaluating the final report from Battelle entitled "Food and Cosmetics, Chemical, Biological, and Radiological Threat Assessment".

FDA participates in a variety of activities intended to promote the safety of foods imported into the U.S. The Agency has developed and is implementing new strategies for imported foods and cosmetics to complement FDA's traditional enforcement approaches. These new approaches are based on cooperative efforts with governments and industries in producing countries to achieve a higher level of protection for U.S. consumers and to prevent safety problems at their source. In the field FDA is increasing: import filer evaluations to ensure integrity of importers and import entry data, collection of samples for laboratory analysis, physical examinations of imported products to ensure safety; the Electronic Laboratory Exchange Network – or eLEXNET- to provide better nationwide access to information on food pathogens and select agents; and, the food labs to CDC Laboratory Response Network to analyze food samples for select agents if there is a food terrorism event. FDA has also developed a risk-based statistical model in concert with other Department of Health and Human Service operating divisions to determine the appropriate frequency and level of

inspectional coverage for imported products. This model takes a "life cycle" approach, utilizing information such as Operational and Administrative System for Import Support- or OASIS- data, post-market surveillance information, the results of foreign good manufacturing practices inspections, physical exams, sample analysis, and information gathered from other governmental authorities.

Further, international food safety, quality and labeling standards have been developed through international consensus within the Codex Alimentarius Commission. These standards have become more numerous and their use as benchmark standards for foods moving in international trade is now recognized specifically by the trade agreements. FDA continues to play, a major role in ensuring that these international standards are based on sound scientific principles and are protective of the health of American consumers. FDA's active participation in the international arena has had and continues to have a very positive impact on the ability of FDA to protect the health of American consumers. FDA's regulatory and scientific expertise has been instrumental in enhancing the strength of international standards for foods and cosmetics and in improving the foreign regulatory systems that oversee the production and safety of products exported to the United States.

Ms. Delauro: With the creation of Operation Liberty Shield, has there been any discussion about looking at the possibility of creating a single food agency? With the threat of a bioterrorist attack on our food supply, do you think it's time we looked at consolidating our food safety system into one agency?

Dr. McClellan: There has been some criticism about the fragmentation of the federal food safety system. Some have even suggested the creation of a single food agency at the federal level. It is clear, however, that organizational reform will not alone solve the problems and that fundamental change is not possible without a major re-write of our nation's existing food safety laws. This Administration has determined that we can best move forward at this time by working collaboratively and effectively to protect the safety of the food supply. Because the Department of Health and Human Services, or DHHS, has the largest responsibility for food safety, roughly 80% of foods produced, at the federal level, our strategy concentrates on what this Department can do to ensure that consumers have access to a safe and wholesome food supply.

A successful food safety system must be built on a foundation of strong science. New and more deadly pathogens and toxins, chemicals and other hazards are entering the food supply, and new technology for production and processing methods may pose new and major challenges to DHHS's ability to protect public health. This Department must be able to keep pace. A strong science base will serve to fortify all aspects of the food safety programs.

DHHS must be able to identify the highest risks to the food supply by collecting data on foodborne illness, as well as potential hazards to the food supply such as pathogens and toxins. New foods - both domestic and imported, new eating habits, and new production technologies make this a difficult task.

The potential hazards to the food supply are varied. FDA has made progress on establishing prevention standards for the riskiest products, such as infant formula, seafood, low acid canned foods, fresh fruits and vegetables, eggs, and juice. However, additional prevention, good manufacturing and other standards are needed to protect new food products and emerging hazards in foods from farm to table. FDA must be vigilant through inspections and testing to assure US consumers are protected. DHHS must continue to educate and inform consumers, industry, States, foreign food safety officials of foodborne hazards and the means to protect their families and or products. DHHS has made significant progress in food safety awareness, through: public/private partnerships, target campaigns to at-risk populations; and, training and technical assistance - but much more can and should be done. US consumer awareness is an integral part of reducing foodborne illness.

SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

Ms. DeLauro: Dr. Gerberding, thank you for updating us on your response to Severe Acute Respiratory Syndrome (SARS). I want to commend you and your entire organization for the work you have done in responding to this worldwide epidemic. As has already been noted, your response to this outbreak is very similar to what your response would be to a bioterrorist outbreak. I recognize that your response to SARS is ongoing, but can you tell us what lessons you have learned thus far, which we can use to be better prepared for a bioterrorist event?

Dr. Gerberding: Some of the lessons learned in the current outbreak of Severe Acute Respiratory Syndrome (SARS) that can be applied to bioterrorism preparedness include:

- Isolation procedures can be implemented. CDC has provided isolation and infection control guidelines to health care workers, SARS patients and their close contacts, schools, workplaces, and others. CDC would respond similarly in a bioterrorism event.
- Appropriate and timely risk communication allays public fears and prevents public panic. An informed public is more likely to cooperate with necessary public health measures when they understand the reasons for implementation of the measures.
- Adjusting staffing levels to maximize Agency response while minimizing fatigue and burnout by rotating team members and leaders during the response as appropriate.
- Using CDC's Laboratory Response Network (LRN) to disseminate diagnostic reagents as soon as they are standardized and available.

- Fine-tuning our approach to contact tracing for airplane exposures within the current smallpox plan. During the SARS investigation, CDC has faced a daunting challenge of trying to track lists of passengers potentially exposed to SARS.

Not only will many of the lessons learned from the SARS outbreak assist in planning for bioterrorism preparedness, but many of the systems already in place to respond to a bioterrorist attack have proved useful in responding to SARS. These measures include

- Activation of CDC's new Emergency Operations Center (EOC) has maximized CDC's response to the epidemic.
- Deployment of trained Emergency Response Teams to assist in the international investigation.
- Channels of communication set up for terrorism are facilitating the rapid dissemination of up-to-date information on SARS.

Ms. DeLauro: I know you've worked hand-in-hand with the World Health Organization (WHO) in this response. Do you have any kind of agreement that would ensure that kind of cooperation in the event of a bioterrorist attack?

Dr. Gerberding: The Centers for Disease Control and Prevention (CDC) and WHO have a long-standing history of cooperation and collaboration in addressing new and emerging threats to the health of the world's population. In April 2000, WHO formalized its partnership with CDC and other international health organizations by creating its Global Outbreak Alert and Response Network (GOARN), which includes more than 110 institutions and networks involved in detecting and responding to significant disease outbreaks. In 2001, the World Health Assembly adopted the resolution "Global Health Security: Epidemic Alert and Response" which formally recognized the collaboration between WHO and its technical partners in the area of epidemic alert and response, to both naturally occurring and intentionally caused outbreaks. In this context, CDC has participated in many WHO international teams responding to disease outbreaks. Not infrequently, the cause is unknown during the initial stages of the investigation, e.g. SARS, or the epidemiology does not conform to the usual pattern for a given disease. An intentionally caused outbreak would likely fit this pattern. Therefore, should there be a bioterrorism attack, whether recognized or not as such from the outset, CDC personnel would be integral parts of the WHO teams responding to the event.

FEDERAL RESPONSE

Ms. DeLauro: How would the Department of Homeland Security be involved in response to a bioterrorist event - can you describe your coordination with them? Who would be at the top of the chain of command in that case?

Mr. Hauer: When the federal government encounters a real or apparent bioterrorism incident, the Secretary of Health and Human Services is responsible for directing the initial response while keeping the Secretary of Homeland Security and the Attorney General, among others, apprised of developments. Under certain circumstances, as described in Homeland Security Presidential Directive #5 (see below), the Secretary of Homeland Security may assume the lead responsibility for directing the federal government's response.

Bioterrorism, like virtually all other forms of terrorism, begins as a local event. Therefore, the initial leadership for response rests with local and state public health officials. Because a bioterrorist event is likely to manifest itself as an outbreak of infectious disease, physicians who encounter the first patients may have no basis to determine, much less suspect, that the disease is of anything other than natural origin. However, when physicians see either unusual symptoms in their patients or an uncommonly large number of patients with otherwise common symptoms, they typically report their observations to local public health authorities.

Based on physicians' case reports, local or state public health officials may have reason to suspect that a bioterrorism event is underway. If so, they typically alert the Centers for Disease Control and Prevention (CDC), a unit of the Department of Health and Human Services (DHHS). At that point, the Secretary of Health and Human Services has the responsibility for leading the initial federal government response -- working through the CDC and other DHHS agencies that may have relevant authorities and expertise (e.g., the Food and Drug Administration), collaborating with other government agencies (e.g., the Federal Bureau of Investigation), and keeping the Department of Homeland Security and the Executive Office of the President appropriately apprised.

Homeland Security Presidential Directive #5 provides for the Department of Homeland Security (DHS) to assume responsibility for coordinating federal government response operations under certain circumstances. In particular, "The Secretary shall coordinate the federal government's resources utilized in response to or recovery from terrorist attacks, major disasters, or other emergencies if and when any one of the following four conditions applies: (1) a federal department or agency acting under its own authority has requested the assistance of the Secretary; (2) the resources of state and local authorities are overwhelmed and federal assistance has been formally requested by the state and local authorities; (3) more than one federal department or agency has become substantially involved in responding to the incident; or (4) the Secretary has been directed to assume responsibility for managing the domestic incident by the President."

SMALLPOX IMMUNIZATION GUIDANCE

Ms. Roybal-Allard: During Phase II of the smallpox immunization plan, nearly 1 million people will be eligible for vaccination against smallpox. Does CDC plan to issue guidance for Plan II to address lingering questions states might have, such as how states should prioritize the next set of people, or whether additional health entities besides health departments would be allowed to vaccinate? If so, when would you expect to issue this guidance?

Dr. Gerberding: CDC has convened a working group that will develop recommendations specific to definitions, procedures, and processes for states to review when moving smallpox vaccination programs into Stage II. The recommendations will be distributed in the form of guidance to states as soon as possible.

Ms. Roybal-Allard: In your testimony, you state that to date, 270,000 vaccine doses have been released to States, and over 29,000 front-line workers have been vaccinated. How do these figures compare with your projections -for this point in time - and what are the additional stumbling blocks that still need to be overcome?

Dr. Gerberding: According to information recently collected by the Association of State and Territorial Health Officials based on a survey of 34 grantees, 15% of states have completed "Phase I", 64% are in the middle of "Phase 1" vaccinations. About 10% of the states are beginning plans for "Phase 2" and about 10% of the states indicated they have chosen to take a "programmatic pause". Some of the barriers to full implementation of Phase 1 in the original timeframe include liability issues, occurrence of myo/pericarditis, and the absence of a national vaccine compensation program.

Ms. Roybal-Allard: In your testimony, you mention that one of the significant gaps in preparedness across the nation is the local capability to identify chemical agents immediately following an exposure incident, so emergency responders understand the nature of what they are facing, and emergency physicians know what they treating. What will be required - including the level of expenditure that will be required - by state and local health agencies to plug this gap, and what specific steps is CDC taking to assist?

Dr. Gerberding: CDC/ATSDR is developing a plan for establishing an early detection system for investigation of human illnesses caused by a chemical or radiological release. Early detection capabilities for chemical or radiological terrorism events will be established using several approaches. One of these is to prepare case-definitions and toxic syndrome descriptions for a group of high-priority chemicals and radiation exposures. An active medical education program will be used to distribute this information to key hospitals and emergency departments throughout the United States. Medical personnel in hospitals and emergency departments will use this information to identify and to report possible terrorism-related illnesses to state health departments and CDC. Once identified, CDC field teams will conduct active case finding. Pre- and post-event early detection efforts for chemical- and

radiological-related illnesses will be coordinated with existing CDC efforts in terrorism-related syndromic surveillance. Although we do not know the exact level of expenditure that will be required for these early detection efforts we have submitted a project for funding in FY04 that includes \$3,000,000.00 to conduct passive surveillance in 6 cities including 10 ER's/city.

BENCHMARKS

Ms. Roybal-Allard: In your testimony, you talk about the use of benchmarks by CDC and HRSA in 2002 to help prepare the states. GAO has now recommended establishing benchmarks as well. Please provide a summary of the benchmarks established by HHS for response to bio-terrorism and provide statistics indicating progress by the states.

Mr. Hauer: The information follows:

FY2002 HRSA Critical Benchmarks

In FY02, the Health Resources Services Administration (HRSA) required recipients to address three critical benchmarks in their bioterrorism workplans. The benchmarks were in three areas: 1) Program Direction; 2) Hospital Preparedness Planning Committee; and, 3) Regional Hospital Plans. From the awardees' April 15, 2002 applications and November 1, 2002 semi-annual progress reports, HRSA reports the following progress on the critical benchmarks.

Critical Benchmark #1: Program Direction. In the area of program direction, 98% of awardees have established leadership at the health department level to ensure coordination of funded activities, i.e., 98% of awardees have designated a Coordinator for Bioterrorism Hospital Preparedness Planning (curriculum vitae describing the education, training and experience for this person is available for 93%).

Critical Benchmark #2: Hospital Preparedness Planning Committee. The second critical benchmark required the establishment of a hospital preparedness planning committee. This hospital preparedness planning committee should meet at least once during the planning phase of the workplan and quarterly during the implementation phase, to provide guidance, direction and oversight to the State health department in planning for bioterrorism response. HRSA project officers reported that 98% of awardees have established the required committee – providing a roster of the planning committee in their application or subsequent submissions. The overwhelming majority of these committees have included representation from the state medical services office, state emergency management agency, state hospital association, state office of rural health, Veterans Administration and military hospitals (if in jurisdiction), and state or regional primary care associations. Ninety percent have provided a description or charter defining the mission and duties of the planning committee. Eighty-three percent of planning committees approved the State or regional hospital preparedness plans submitted to HRSA in FY2002.

Critical Benchmark #3: Regional Hospital Plans. The third critical benchmark calls for the development of regional hospital plans. Regional hospital plans to provide surge capacity during a terrorist attack are essential. It is critical that state health departments plan for a potential epidemic involving at least 500 patients in each state or region. Recognizing that many of these patients may come from rural areas served by referral centers in metropolitan areas, planning must include the surrounding counties likely to impact the resources of these cities. Fifty-nine percent of state health departments have developed plans for potential epidemics involving at least 500 patients. Slightly over half (56%) of plans address overcrowding and the need for hospital diversion, anticipating that large numbers of acute casualties will arrive on their own or by ambulance. Sixty-one percent describe making provisions for isolation and quarantine including Type C (contagious) facilities.

FY2002 CDC Critical Benchmarks

For FY02, the Centers for Disease Control and Prevention (CDC) had several critical benchmarks for awardees to address. For the FY02 application, eligible jurisdictions were asked to submit a timeline for various elements of their workplan. Most submitted timelines; however, the intent was for the jurisdictions to make progress on achieving the objectives associated with those timelines over the course of the budget year.

As of November 2002 (when the awardees submitted their first semi-annual progress reports), CDC reported that nearly 95% of awardees established Advisory Committees for their Bioterrorism Preparedness and Response Programs. Ninety-five percent of the awardees have developed systems for "24/7" notification or activation of their plans. Eighty-two percent have coordinated their response plan development with local, regional, and federal response plans, including planning efforts by hospitals funded under the HRSA cooperative agreements. Most awardees (87%) have developed plans and infrastructure to manage and distribute Strategic National Stockpile, formally the National Pharmaceutical Stockpile, items that they would request in the event of an emergency or terrorist attack. Recognizing that bioterrorism response begins locally, 73% of the states have distributed cooperative agreement funds to the local levels within their states; however, there are several states that do not have local or county health department structures.

Overall, CDC awardees reported short-term achievements in the areas of increased preparedness, training, hiring staff, developing plans, committees and relationships, establishing MOUs, and testing plans. Barriers often noted were: lack of best practices, shifting priorities (for both programs and current staff), pressure to accelerate activities more quickly than feasible, lack of skilled personnel, and cumbersome state hiring processes.

When asked if the State has an interim plan for risk communication and information dissemination to educate the public regarding exposure risks and effective public response, 76% stated that they did—and 47% had tested that interim plan. Timelines have been established by 96% of States for ensuring 90% Health Alert Network coverage in each State. Twenty respondents answered questions about

exercising and testing plans. Fifty-five percent (eleven of those 20) held exercises. Some awardees (25%) tested new epidemiology and surveillance response plans. Twenty percent tested information dissemination by sending notifications out to health care providers and the community through the HAN. Most awardees framed their testing experience as tabletop exercises, and referred to activation of systems to monitor and control the outbreak of West Nile Virus experienced across the U.S. in summer 2002.

FY2003 Office of the Secretary Cross-Cutting Benchmarks

For FY2003 the Office of the Secretary of HHS has developed five critical cross-cutting benchmarks that states and other jurisdictions must address in their FY03 workplans. These benchmarks are intended to integrate state activities related to public health preparedness with those related to health care system preparedness. These benchmarks are:

- **Incident Management.** This benchmark is intended to help states and local governments prepare for their eventual participation in the National Incident Management System (NIMS), which is prescribed in Homeland Security Presidential Directive #5 (HSPD-5). NIMS is to cover all incidents (natural and unnatural) for which the federal government deploys emergency response assets. The Secretary of Homeland Security is responsible for leading the development and implementation of NIMS.
- **Joint Advisory Committee for CDC and HRSA Cooperative Agreements.** Establish and operate an Advisory Committee to assist the jurisdiction's senior public health official in overseeing both the CDC and HRSA Cooperative Agreements.
- **Laboratory Connectivity.** Establish operational relationships among the various types of analytical laboratories within the jurisdiction (and other jurisdictions as appropriate) that are relevant to preparedness for and response to bioterrorism and other public health emergencies.
- **Laboratory Data Standard.** Adopt the Logical Observation Identifiers Names and Codes (LOINC), where applicable, as the standard codes for electronic exchange of laboratory results and associated clinical observations between and among clinical laboratories of public health departments, hospitals and other entities, including academic health centers, that have a role in responding to bioterrorism and other public health emergencies.
- **Jointly Funded Health Department/Hospital Activities.** Develop and maintain a database displaying activities funded jointly by the CDC and HRSA cooperative agreements and, as applicable, other sources.

CDC and HRSA have the following FY2003 benchmarks that will serve to guide the states in developing their workplans to prepare for and respond to bioterrorism, infectious disease outbreaks and other public health emergencies. CDC's benchmarks appear first, followed by HRSA's benchmarks.

CDC Critical Benchmarks

Critical Benchmark #1: Develop and maintain a financial accounting system capable of tracking costs by focus area, critical capacity, and funds provided to local health agencies.

Critical Benchmark #2: Develop or enhance scalable plans that support local, statewide, and regional response to incidents of bioterrorism, catastrophic infectious disease, such as pandemic influenza, other infectious disease outbreaks, and other public health threats and emergencies. Plans must include detailed preparations to rapidly administer vaccines and other pharmaceutical, and to perform healthcare facility based triage and provide short-term acute psychosocial interventions as well as longer-term services to large populations. This should include the development of emergency mutual aid agreements and/or compacts, and inclusion of hospitals.

Critical Benchmark #3: Maintain a system for 24/7 notification or activation of the public health emergency response system.

Critical Benchmark #4: Exercise all plans on an annual basis to demonstrate proficiency in responding to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies.

Critical Benchmark #5: (HRSA/CDC Cross-Cutting Activity) Review and comment on documents regarding the National Incident Management System (NIMS), develop and maintain a description of the roles and responsibilities of public health departments, hospitals, and other health care entities in the Statewide incident management system and, where applicable, in regional incident management systems.

Critical Benchmark #6: Develop or maintain, as appropriate, a Strategic National Stockpile (SNS) preparedness program within the recipient organization's overall terrorism preparedness component, including full-time personnel, that is dedicated to effective management and use of the SNS statewide. This SNS preparedness program should give priority to providing appropriate funding, human and other resources, and technical support to local and regional governments expected to respond should the SNS deploy there.

Critical Benchmark #7: Complete development and maintain a system to receive and evaluate urgent disease reports and to communicate with and respond to the clinical or laboratory reporter regarding the report from all parts of your state and local public health jurisdictions on a 24-hour-per-day, 7-day-per-week basis.

Critical Benchmark #8: With local public health agencies, identify and maintain a current list of physicians and other providers with experience and/or skills in the diagnosis and treatment of infectious, chemical, or radiological diseases or conditions possibly resulting from a terrorism-associated event (for example, those who have seen and treated smallpox) who may serve as consultants during a public health emergency.

Critical Benchmark #9: Establish a secure, Web-based reporting and notification system that provides for rapid and accurate receipt of reports of disease outbreaks and other acute health events that might suggest bioterrorism. Include provision for multiple channels for routine communications (e.g., Web, e-mail) and alert capacity for emergency notification (e.g., phone, pager) of key staff.

Critical Benchmark #10: To develop and implement a jurisdiction-wide program that provides rapid and effective laboratory response for chemical terrorism by establishing competency in collection and transport of clinical specimens to laboratories capable of measuring chemical threat agents.

Critical Benchmark #11: At least annually, assess adequacy of state and local public health response to catastrophic infectious disease such as pandemic influenza, other outbreaks of disease and other public health emergencies.

Critical Benchmark #12: Complete and implement an integrated response plan that directs how public health, hospital-based, environmental, veterinary and agricultural laboratories will respond to a bioterrorism incident, to include: (a) roles and responsibilities; (b) inter- and intrajurisdictional surge capacity; (c) how the plan integrates with other department-wide emergency response efforts; (d) protocols for safe transport of specimens by air and ground; and (e) how lab results will be reported and shared with local public health and law enforcement agencies, ideally through electronic means.

Critical Benchmark #13: Ensure capacity exists for Laboratory Response Network (LRN) validated testing for all Category A agents and other Level B/ C protocols as they are approved.

Critical Benchmark #14: Conduct at least one simulation exercise per year, involving at least one threat agent in Category A, that specifically tests laboratory readiness and capability to perform from specimen threat assessment, intake prioritization, testing, confirmation, and results reporting using the LRN website.

Critical Benchmark #15 – APPLICABLE TO LEVEL-ONE LABORATORIES ONLY) Hire and train a chemical terrorism laboratory coordinator (chemist or medical technologist) and assistant coordinator to advise the laboratory director, the State Terrorism Coordinator and other public health and environmental health officials about chemical terrorism incidents and preparedness. These individuals are responsible for

ensuring the proper collection, labeling, and shipment of blood, urine, and other clinical specimens required in response to known or suspected chemical terrorism incidents and for ensuring associated data and communication requirements are met.

Critical Benchmark #16 – APPLICABLE TO LEVEL-TWO LABORATORIES ONLY) Participate in at least one exercise per year that specifically tests chemical terrorism laboratory readiness and capability to detect and identify at least one chemical-threat agent.

Critical Benchmark #17 – APPLICABLE TO LEVEL-THREE LABORATORIES ONLY Participate in at least one exercise per year that specifically tests chemical terrorism laboratory readiness and capability to detect and identify at least two chemical-threat agents.

Critical Benchmark #18: Implement a plan for connectivity of key stakeholders involved in a public health detection and response including a 24/7 flow of critical health information, such as clinical data (build according to IT functions #1-3 in Appendix 4), alerts, (build according to IT Functions #7-9 in Appendix 4) and critical event data, (IT Functions #1-3 in Appendix 4), among hospital emergency departments, state and local public health officials, law enforcement, and other key participants (e.g. physicians, pharmacies, fire departments, 911 Centers)

Critical Benchmark #19: Ensure, by testing and documentation, at least 90 percent of the key stakeholders involved in a public health response can receive and send critical health information including alerts and critical event data. (Build according to Appendix 4 - IT Functions and Specifications.)

Critical Benchmark #20: Routinely assess the timeliness and completeness of the redundant method of alerting, as it exists to reach participants in public health response.

Critical Benchmark #21: Ensure that the technical infrastructure exists to exchange a variety of data types, including possible cases, possible contacts, specimen information, environmental sample information, lab results, facilities, and possible threat information. (Build according to IT Functions #1-9 in Appendix 4).

Critical Benchmark #22: (HRSA/CDC Cross-Cutting Activity) Adopt and implement LOINC as the standard for electronic exchange of clinical laboratory results and associated clinical observations between and among public health department laboratories, hospital-based laboratories, and other entities, including collaborating academic health centers, that have a major role in responding to bioterrorism and other public health emergencies.

Critical Benchmark #23: Complete a plan for crisis and emergency risk communication (CERC) and information dissemination to educate the media, public, partners and stakeholders regarding risks associated with the real or apparent threat and an effective public response.

Critical Benchmark #24: Conduct training, drills, and exercises involving your communication systems to ensure channels of communication to inform the public, partners, and stakeholders about recommendations during public health emergencies work in a timely and effective manner.

Critical Benchmark #25: Develop and execute a training plan (1 year), which ensures priority preparedness training is provided across all Focus Areas to the state and local public health workforce, healthcare professionals, and laboratorians.

HRSA Benchmarks

Critical Benchmark #1: Develop and maintain a financial accounting system capable of tracking expenditures by priority area, by critical benchmark, and by funds allocated to hospitals and other health care entities.

Critical Benchmark #2-1: Establish a system that allows the triage, treatment and disposition of 500 adult and pediatric patients per 1,000,000 population (or no fewer than 500 patients per awardee jurisdiction), with acute illness or trauma requiring hospitalization from a biological, chemical, radiological or explosive terrorist incident.

Critical Benchmark #2-2: Upgrade or maintain airborne infectious disease isolation capacity to have at least one negative pressure, HEPA-filtered isolation facility per awardee, to be placed in accord with the findings of the awardee's needs assessments. Such facilities must be able to support the initial evaluation and treatment of 10 adult and pediatric patients at a time having a clinical contagious syndrome suggestive of smallpox, plague or hemorrhagic fever, prior to movement to a definitive isolation facility.

Critical Benchmark #2-3: Establish a response system that allows the immediate deployment of 100 or more additional patient care personnel per 1,000,000 population in urban areas, and 50 or more additional patient care personnel per 1,000,000 of population in rural areas, that would meaningfully increase hospital patient care surge capacity.

Critical Benchmark #2-4: Develop a system that allows the credentialing and supervision of clinicians not normally working in facilities responding to a terrorist incident.

Critical Benchmark #2-5: Establish local or regional systems whereby pharmacies based in hospitals or otherwise participating in the local or regional health care response plan have surge capacity to provide pertinent pharmaceuticals in response to bioterrorism or other public health emergencies. The surge cache should be within the stock rotational capacity of the participating pharmacies, to prevent shelf-life expiration of the medications, vaccines, and supplies. These systems must complement the Strategic National Stockpile (SNS).

Critical Benchmark #2-6: Ensure adequate personal protective equipment (PPE) to protect 100 or more health care personnel per 1,000,000 population in urban areas, and 50 or more health care personnel per 1,000,000 population in rural areas, during a biological, chemical or radiological incident.

Critical Benchmark #2-7: Ensure that adequate portable or fixed decontamination systems exist for managing 500 adult and pediatric patients and health care workers per 1,000,000 population, who have been exposed to biological, chemical or radiological agents.

Critical Benchmark #2-8: Establish a system that provides for a graded range of acute psychosocial interventions and longer-term mental health services to 5,000 adult and pediatric clients and health care workers per 1,000,000 population exposed to a biological, chemical, radiological or explosive terrorist incident.

Optional Benchmark #2-9: For awardees choosing to fund the Trauma and Burn Care Capacity section, enhance statewide trauma care capacity to be able to respond to a mass casualty incident due to terrorism. This plan should ensure the capability of providing trauma care to at least 50 severely injured adult and pediatric patients per million of population per day.

Critical Benchmark #2-10: Establish a secure and redundant communications system that ensures connectivity during a terrorist incident between health care facilities and state and local health departments.

Critical Benchmark #3: Develop a mutual aid plan for upgrading and deploying EMS units in jurisdictions they do not normally cover, in response to a mass casualty incident due to terrorism. This plan must ensure the capability of providing EMS coverage for at least 500 adult and pediatric patients per 1,000,000 population per day.

Critical Benchmark #4-1: Implement a hospital laboratory program that is coordinated with currently funded CDC laboratory capacity efforts, and which provides rapid and effective hospital laboratory services responding to terrorism and other public health emergencies.

Critical Benchmark #4-2: Enhance the capability of rural and urban hospitals, clinics, emergency medical services systems and poison control centers to report syndromic and diagnostic data that is suggestive of terrorism to their associated local and state health departments on a 24-hour-a-day, 7-day-a-week basis.

Optional Benchmark #5: For awardees choosing to fund the Education and Training Preparedness section, develop education and training programs for adult and pediatric hospital, outpatient and prehospital health care professionals responding to a terrorist incident.

Critical Benchmark #6: As part of a written evaluation strategy of the awardee's program, conduct at least one bioterrorism disaster exercise in the jurisdiction during FY 2003 that covers a large-scale epidemic scenario affecting both adults and children.

Ms. Roybal-Allard: You also mention a project to establish a "best practices" repository for the states. What is the process for identifying a "best practice" in a state, and how does HHS disseminate information about best practices?

Dr. Gerberding: Best Practices generally refer to programs and strategies that are known to be effective based on research and evaluation. Best practices have been adopted by many organizations in order to improve programs and interventions at the local, state, and national level. Upon extended implementation and evaluation, the community becomes more knowledgeable about what works and what does not. A state may then select, develop or adapt programs to its individual needs. Best practices in preparedness for and response to bioterrorism and other public health emergencies at the state and local levels are not plentiful. However, there are exemplars, developed and implemented in various parts of the country that could serve as models with modifications made to tailor them to local needs and circumstances. HHS will be establishing a program to identify best practices, validate them where feasible, and will disseminate this information from its websites, as well as through the CDC and HRSA project officers.

STATE AND LOCAL HOSPITAL PREPAREDNESS

Ms. Roybal-Allard: In your testimony, you mention that states are making good progress in completing needs assessments and implementing high priority components, but also say that "surge" capabilities are yet to be tested, and only 40% of hospitals have plans for isolation and treatment of infectious disease epidemics. What is the status of hospital preparedness? Please provide state-by-state accounting.

Dr. Duke: A state-by-state accounting is not yet available, but evaluation efforts are being undertaken to answer these questions. One is a hospital preparedness survey being developed by the Agency for Healthcare Research and Quality (AHRQ) under an intra-agency agreement with HRSA. This will be designed to be used in subsequent cooperative agreement applications. Additional evaluation tools are under development. With regard to the 40% figure that you referenced, that related to the hospitals in Pennsylvania that responded to a state-specific survey.

The program has collected data from information provided by grantees in their 2002 applications and their November 2002 semi-annual report. Some of the significant benchmarks are summarized below:

Regional Hospital Plans

- 59% of grantees reportedly have planned for a potential epidemic involving at least 500 patients in the State or region.

- 75% of the grantees included a timeline that describes the approach to development and implementation of the regional hospital plan for large-scale epidemics in their application.
- 58% of plans describe increasing hospital bed capacity to accommodate increases in admissions from an infectious disease epidemic over an extended period of time.

Medications and Vaccines

- 95% of plans describe the State health department readiness plan for immediate receipt and distribution of antibiotics and smallpox vaccines made available from Federal sources.

Communications

- 72% of plans address gaps in the communications systems among hospital emergency departments, outpatient facilities, EMS systems and State and local emergency management, public health and law enforcement agencies, as they relate to bioterrorism response.

Personal Protection, Quarantine, and Decontamination

- 56% of plans describe how existing decontamination systems will be upgraded to allow for large numbers of patients exposed to particulate infectious material from an airborne or environmental release (such as fixed hospital units, portable units, or Disaster Medical Assistance Teams (DMATs) capable of mobile decontamination).

Evaluation efforts are currently being undertaken to more fully answer these questions. One is a hospital preparedness survey being developed by the Agency for Healthcare Research and Quality (AHRQ), under an intra-agency agreement with HRSA. This will be designed to be used in subsequent cooperative agreement applications. Additional evaluation tools are under development

THURSDAY, APRIL 3, 2003.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

WITNESSES

THOMAS A. SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

KERRY N. WEEMS, ACTING ASSISTANT SECRETARY FOR BUDGET, TECHNOLOGY, AND FINANCE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. REGULA. Well, we will get started and we will move it as quickly as possible. The supplemental is on the floor today and I don't think we can meet because it is an appropriations issue. So I would like to try to get through before that starts so we can finish the hearing.

And, Mr. Scully, we are happy to welcome you. This is your last hearing, and this is—oh, the last hearing we will have with your budget officer. Geez, be careful, particularly in this day and the particular circumstances. On your budget officer Elaine Raubach. Okay. And she is here as a backup and my staff tells me you have been a great help to us and we certainly wish you well in whatever your new endeavor is. Where are you going?

Mr. SCULLY. She is still in negotiations, Mr. Chairman. We are working on her. She claims she is retiring in January.

Mr. REGULA. Oh, retiring. You are too young.

Mr. SCULLY. 31 years.

Mr. REGULA. Well, we wish you well. Okay. Mr. Scully, if you will just summarize your remarks.

Mr. SCULLY. Mr. Chairman, thank you. I will be as quick as I can. Thank you for acknowledging Elaine. We are still trying to talk her into staying. We hope she doesn't retire in January. For 31 years she has done a tremendous job.

If I could, I will just take 2 minutes out of my testimony to do something else that I think is important, which is to acknowledge the CMS has 10 reservists that have been called up in the last couple of weeks, and I will take 2 seconds to run through their names for the record. Michael Kristian, the Baltimore office is at Andrews Air Force Base; James Cratty of the Baltimore office is in Middle River, Maryland; David Connolly of the Baltimore office is at the Pentagon; Francis Crowley of the Atlanta office is at Camp Pendleton in California; Caroline Krewson is actually a lieutenant colonel in charge of the communications for the European Systems Command in Stuttgart, Germany. She is in the San Francisco office. Teresa Trimble from our Baltimore office is a lieutenant colonel who we haven't been able to identify where they sent her. Marvin Washington from the Baltimore office is in California moving on to other places. Kristine Bradsher of the Baltimore office is in Bethesda, Maryland. James Fuller of the Baltimore office is in

Washington working on homeland security, and Bill Rogers, who is my personal physician adviser and a very good personal friend of mine, is in Kuwait on his way to Iraq today. He is an emergency room doctor and is very likely to be seeing front line action.

So we are very proud of those people and very hopeful they will be back at CMS very soon. But thank you for letting me acknowledge those folks at the beginning of the hearing, Mr. Chairman.

HEALTHY START, GROW SMART

I also want to thank you for another initiative that is close to the Bush administration's heart, which is Healthy Start, Grow Smart, which I know you put money in for last year, \$13 million, to give each new mom, 1 brochure a month for the first 12 months of life. That is a big priority for the Administration that you really did an enormous amount to help us out on and we are very appreciative.

CMS'S WORKLOADS

As a quick overview, CMS serves 82 million beneficiaries between the programs we have. Our budget for this year is, believe it or not, \$592 billion just in the services we provide. We will process 1.1 billion claims, respond to 45 million inquiries from beneficiaries, hear 8 million appeals, do 23,000 inspections, and respond to 48,000 complaints about health care facilities.

APPEALS REFORM

I am going to focus on one particular issue briefly. This is a huge priority for me and a big challenge for the agency. From the beginning of the program, Medicare was part of Social Security and for years Social Security has heard our appeals.

In the President's budget this year it is proposed that Medicare will take over that appeals process, which is about 80,000 appeals. Out of our trust funds we give Social Security about a billion dollars a year to take care of constituent concerns and to hear hearings for our Medicare appeals. Of that, \$90 million we transfer just for hearings. As of October 1st we are taking that duty over. We have to essentially recreate an entire administrative law judge system in Medicare to take over that burden from Social Security. We think it is the right thing to do. Jo Ann Barnhart at Social Security thinks it is the right thing to do.

The average turnaround time now to hear a Medicare appeals case is 330 days. As you know, Mr. Thomas passed the streamlining of that 2 or 3 years ago that we have not yet been able to implement. We have asked for money in our budget, \$129 million, both to implement the Benefits Improvement and Protection Act (BIPA) appeals that Chairman Thomas and the Ways and Means Committee feel so strongly about and to take over the Medicare hearing process from Social Security and to pull that off by October 1st. But under the best of circumstances it would be an unbelievable job to pull that off smoothly by October 1st. But we have one major problem in that there is a lawsuit that prohibits us from hiring administrative law judges. So we are going to have quite a challenge in front of us.

A rather unfair article hit the front page of the New York Times a few weeks ago, but I think it is the right thing to do. I think we are going to do a very good job of hopefully transitioning with Social Security to take this over. But obviously 80,000 Medicare appeals a year is a big job. It is very sensitive to seniors. We are very happy to go hire Administrative Law Judges (ALJs) to do this if we are allowed to, but my number one priority would be to ask the committee if we could get \$129 million in the budget. That is going to be an unbelievably herculean task to pull this off by October 1st, and I think if there is anything in this agency as likely to be an administrative problem that is going to cause problems for the Congress and the administration in the next year, this is probably it.

So we really appreciate that your staff has been terrific. We appreciate your support in working on that and trying to get the resources to hire the ALJs and to do these modernizations this year.

CMS'S DISCRETIONARY BUDGET

Just a quick overview, and I will just wrap up because I know your time is short. As I said, we have \$592 billion of entitlement funds we will spend next year. Our administrative fund request is roughly \$2.7 billion, which is a 6.6 percent increase over last year. Our administrative costs work out to be about .5 percent of the Medicare funds that we will spend.

We have a lot of other major priorities. A major priority of the Department is systems modernization, for which we have asked \$65 million.

CMS'S ACCOMPLISHMENTS

There are many other things we have done in the last year that we are proud of. We have done a lot to improve beneficiary communications to open up the agency to work better with our constituent groups and to be much more responsive to the beneficiaries and the patients that we work with. I have a long list I would be happy to go through but I know you are in a hurry so I won't. But I would be happy to submit the testimony for the record and am happy to talk to the committee and respond to questions.

Thank you, Mr. Chairman.

[The statement of Mr. Scully follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Fiscal Year 2004 Budget Request

**Witness appearing before the
House Subcommittee on Labor-HHS-Education Appropriations**

Thomas A. Scully
Administrator, Centers for Medicare & Medicaid Services

Accompanied by:

Kerry N. Weems
Acting Assistant Secretary for Budget, Technology, and Finance

April 3, 2003

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Statement by

Thomas A. Scully
Administrator, Centers for Medicare & Medicaid Services

on

Fiscal Year 2004 President's Budget Request
for the Centers for Medicare & Medicaid Services

Good morning Chairman Regula and members of the Subcommittee. I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2004 budget request and to answer your questions. First, I'd like to give you an overview of our budget, and tell you about some of our recent activities, as well as the priorities Secretary Thompson and I have for FY 2004. As always, we appreciate your support and look forward to working with you, Chairman Regula, and with the Members of this Subcommittee.

CMS is the Federal agency responsible for overseeing Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). CMS also oversees the Medigap insurance industry and enforces the Clinical Laboratory Improvement Amendments (CLIA) and health insurance reform enacted under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. We are also responsible for implementing hundreds of statutory provisions enacted in recent years, including HIPAA, the Balanced Budget Act (BBA) of 1997, the Balanced Budget Refinement Act (BBRA) of 1999, the Ticket to Work and Work Incentives Improvement Act

of 1999, the Benefits Improvement and Protection Act (BIPA) of 2000, and, recently, the Trade Act of 2002.

CMS oversees one of the largest budgets of any agency in the Federal government. It pays one-third of national health expenditures and provides over half of the revenues of many hospitals and other health care providers. Approximately 82 million beneficiaries, almost 30 percent of all Americans, rely on CMS's programs for health care coverage. For 38 years, Medicare and Medicaid have helped pay medical bills for millions of older and low-income Americans, providing them with comprehensive health benefits they can count on. Few programs, public or private, have such a positive impact on so many Americans. We do this with the help of over 65,000 State and local employees and contract employees.

CMS is committed to administering Medicare and Medicaid effectively and efficiently and to providing essential services to millions of health care consumers and the health care providers that serve them. For almost two years, we have worked to make Medicare a more user-friendly, beneficiary-centered program and to make it clear to the Americans who rely on our programs that CMS is responsible for administering them. We have also moved the agency toward being more citizen-centered, and more open and responsive to the needs and concerns of Medicare and Medicaid beneficiaries and their health care providers. I believe that this new attitude influences everything we do and sets the tone for how we interact with our

stakeholders. We have made many changes and improvements, with more still to come.

First and foremost, I want to talk about Medicare appeals reform. With your help, we plan to implement key provisions of the Benefits Improvement and Protection Act (BIPA) of 2000 and assume the Medicare hearing function currently performed by administrative law judges (ALJs) at the Social Security Administration (SSA).

We believe that the Medicare hearing function is more appropriately housed within CMS, and we are moving forward to achieve this. However, this is an especially challenging time for this workload. Right now, SSA ALJs take about 330 days to complete a Medicare hearing. Clearly, this is an unacceptable level of customer service. In BIPA, Congress sought to alleviate this problem by mandating a 90-day processing time for these cases, but we don't believe this affords sufficient time to properly develop and adjudicate an appeal, given the volume of work received. This is a particular concern given the "escalator clause" which allows beneficiaries to advance their case to the next level of appeal if a decision is not rendered within the statutory timeframe. This could result in hearings moving to the Departmental Appeals Board, only to be remanded back to an ALJ if they are not sufficiently developed, setting up an unending circle that would diminish beneficiary service rather than improve it.

We have proposed that all of the BIPA statutory timeframes be lengthened. We believe that more realistic timeframes, even if only at the initial levels of the appeal process, will reduce the number of cases at the higher, more costly adjudication levels. We look forward to working with you and the authorizing Committees toward the enactment of this proposal.

A major factor in the ability to complete higher levels of adjudication on a timely basis envisioned by BIPA 521 is the availability of trained ALJs. We are considering alternative approaches, including the possibility of using mechanisms other than ALJs. For the past several years, there has been a moratorium on hiring new ALJs. This has contributed to SSA's problem issuing timely ALJ decisions for both their cases and ours. They have neither enough ALJs to reduce timeframes nor the ability to hire more. Therefore, both Medicare and disability appeals are taking too long. Despite a recent court ruling lifting the moratorium, it is unclear to us at this time when agencies will again be able to hire ALJs. Moreover, even if we were to have the authority to hire ALJs, we may not be able to hire a sufficient number, since all agencies that use ALJs have been subject to the moratorium and its consequences. This is a difficult challenge.

By transferring the Medicare appeals workload to CMS, SSA will be able to concentrate its efforts on the disability appeals backlog, but they will need their full contingent of ALJs for this effort. Since SSA needs all the ALJs they have just to meet their disability workloads, our chances of meeting our staffing needs with

existing ALJs are very slim. If there is no change to the manner in which Medicare appeals are heard, there is a danger that beneficiaries will lose an appeal right they have had for years and that customer service will decline even more. Our budget seeks a way around this problem by including appropriation language that, if enacted, will give the Secretary the option to consider other approaches. We count on your support for this provision to help us improve beneficiary service.

While we have agreed with SSA in principle to assume responsibility for the Medicare hearings function effective October 1, 2003, we are still working out the details of the workload transfer.

Another aspect of appeals reform under BIPA section 521 involves the implementation of a new entity, qualified independent contractors or "QICs," which will review second-level appeals. Although BIPA requires that we contract with "at least 12" QICs, we have proposed contracting with no fewer than four QICs. We believe that consolidating responsibilities into four such entities will be more efficient and cost effective.

Finally, we are proposing a change in the implementation schedule. We believe it will take us 16 months, after receipt of funding, to establish the QICs and start processing cases. Extending the implementation date would be more realistic and would give us time to bid for and contract with these new entities, and to engage in start-up activities such as hiring and training staff. It will also give us time to develop

an electronic case control system that will help CMS manage these new workloads and meet the BIPA requirement that each appellant have access to the status of the appeal. This system will make the appeals process more efficient by improving case tracking and record development.

We also want to get started on implementing the appeals process for coverage determinations as required by BIPA section 522.

We estimate that we will need \$129 million in FY 2004 to accomplish these reforms. This includes \$126 million to implement the Section 521 provisions, amended as we have proposed, and the related Medicare hearing function, and \$3 million for start-up activities under section 522. I want to emphasize that this level of funding assumes enactment of the proposed BIPA modifications and the provision regarding increased flexibility in the way Medicare hearings are conducted.

Next, I'd like to briefly describe the progress we've made on some of the Secretary's priorities. First, we have enhanced our outreach and education activities with improved *Medicare & You* educational efforts. This includes a continuing advertising campaign, a continuation of expanded operating hours—24 hours/day, seven days/week—at the 1-800-MEDICARE call centers to better meet beneficiaries' needs, and improved Internet access to comparative information. The volume of calls continues to increase at a rate of about 30 percent each year. In FY 2002, we introduced a new beneficiary decision tool—the Medicare Personal Plan Finder—to our

www.medicare.gov website allowing seniors, family members, and caregivers to compare benefits, costs, options, and provider quality information.

Together with the Department, we recently launched the national Nursing Home Quality Initiative which provides comparative information about the quality of nursing homes. This is an important step in CMS's comprehensive quality strategy. A recently released CMS study of 22 health care measures found that medical care for Medicare beneficiaries has improved significantly since 1998. We believe that public reporting initiatives can further improve the quality of health care delivery for our beneficiaries. We plan to include similar information on home health agencies in FY 2003.

We are also improving responsiveness to beneficiaries and providers. Our "open door" policy forums facilitate information sharing and improve communication between the agency and its partners and beneficiaries. We have held more than 140 of these meetings with more than 2,700 in-person participants and 15,700 participants on our toll-free call-in lines. We have also established key contacts for the States to promote direct communication between CMS staff and beneficiary groups. Furthermore, we have worked diligently over the past two years to reduce the regulatory burden on providers so that they can spend more time taking care of patients. Many of our actions have come from recommendations made by the Secretary's Advisory Committee on Regulatory Reform, of which CMS was an active

member. We believe these are important strides in our goal to become more customer-focused.

Although we have made significant progress, we still have many important plans for FY 2004. First and foremost is strengthening Medicare, one of the Administration's top priorities. The President's budget dedicates \$400 billion over ten years to support the President's framework for improvements and comprehensive Medicare modernization. This includes providing access to prescription drug coverage for all beneficiaries, providing incentives to expand and enhance managed care options, and modernizing fee-for-service by protecting beneficiaries against high out-of-pocket costs. I want to emphasize that the President's framework provides beneficiaries with more options—it does not take away options. Medicare beneficiaries who like traditional Medicare will be able to stay in traditional Medicare, with some improvements. Other beneficiaries will have other choices that may better suit their health care needs.

This budget also supports the Administration's proposal to modernize the Medicaid and SCHIP program by introducing more State flexibility and fiscal stability into the program. Under our proposal, States would have the option of continuing in the current Medicaid program or choosing partnership allotments. They will also be given significant flexibility to design health insurance options for their uninsured populations. In addition, the budget proposes extending the availability of expiring SCHIP funds until FY 2004.

Our request also includes significant new efforts to help disabled persons and their families. The New Freedom initiative promotes home and community-based care and represents part of the Administration's effort to make it easier for Americans with disabilities to be more fully integrated into their communities. The budget also proposes the extension of two programs—the Transitional Medical Assistance program and a program to pay Medicare Part B premiums for certain low-income beneficiaries (QI-1).

In an effort to make the Federal Government more responsive, we have been working aggressively to improve the Medicaid and SCHIP waiver process. CMS has given States more flexibility to expand insurance coverage to the uninsured through the development of the Health Insurance Flexibility and Accountability Demonstration Initiative waiver and through the new Pharmacy Plus waiver. In addition, we have developed Independence Plus waivers, which expedite the ability of States to offer families greater opportunities to take charge of their own health and direct their own care. Streamlined templates were developed for these three types of waivers, which facilitate provision of information and can streamline Federal review and approval.

Another high priority for us is improving our accountability. We are refocusing our program integrity efforts so that we can better differentiate between fraudulent providers and those who make honest billing mistakes. We also plan to use \$20 million from the Health Care Fraud and Abuse Control account to improve the

fiscal integrity of the Medicaid and SCHIP programs and to strengthen Federal oversight of the States' financial practices.

We are also committed to improving our financial performance. Our FY 2004 request includes \$57 million to continue building a financial management system that is compliant with the Federal Financial Management Improvement Act. This system, the Healthcare Integrated General Ledger Accounting System (HIGLAS), is a vital component in the Secretary's initiative to centralize the Department's financial accounting processes through its Unified Financial Management System. When fully implemented, HIGLAS will integrate CMS financial data in a uniform way and replace our current legacy systems.

In addition, our FY 2004 budget is predicated on achieving greater administrative efficiency. This includes managing our workforce more effectively, increasing employee skill levels, responding to Congress and other groups more promptly, and managing our work more strategically. Although we already accomplish most of our operational activities through outside contractors, we continue to analyze opportunities for competitive sourcing.

Finally, I would like to say a word about the Government Performance and Results Act (GPRA) and our annual performance plan. This plan complements and supports the agency's FY 2004 budget, and is integral to it. The agency is confident

that performance measurement under GPRA will substantially improve management of CMS and its programs.

One of our GPRA goals is to reduce improper payments made under the Medicare fee-for-service (FFS) program. We have reduced the national FFS error rate by more than half since the Department began tracking it in FY 1996. To build on this success, we will fully implement, in FY 2003, a Comprehensive Error Rate Testing program which will identify provider- and contractor-specific error rates so that we can take more effective corrective action and better manage Medicare contractor performance. We are also committed to reducing Medicaid and SCHIP payment error rates. This request supports the development of payment accuracy measurement methodologies for these programs.

Now I would like to discuss CMS's FY 2004 budget request and the three accounts for which this Committee makes appropriations: Grants to States for Medicaid; Payments to the Health Care Trust Funds; and CMS Program Management. I will briefly highlight the first two accounts and then discuss CMS's Program Management request in more detail since Program Management funds are key to accomplishing our priorities.

GRANTS TO STATES FOR MEDICAID

In FY 2004, the Medicaid program will serve more than 42 million eligible persons. Federal Medicaid obligations for FY 2004 are estimated at almost

\$177 billion, an increase of 8.8 percent over the FY 2003 estimate. Combined Federal and State Medicaid expenditures are projected to be \$310.4 billion in FY 2004, of which the Federal share is about 57 percent.

PAYMENTS TO HEALTH CARE TRUST FUNDS

Our FY 2004 request of \$95.1 billion includes a Federal general revenue contribution to the Supplementary Medical Insurance (SMI) Trust Fund of \$94.5 billion, an increase of \$13.6 billion from the FY 2003 appropriation.

PROGRAM MANAGEMENT

Our FY 2004 Program Management request is \$2.7 billion, an increase of \$168.6 million, or 6.6 percent, over the enacted FY 2003 appropriation. This funding level will allow us to perform our operational functions and fund key budget priorities such as implementing appeals reform and improving beneficiary education. This budget supports a total of 4,486 FTEs, a decrease of 175 FTEs from our current FY 2003 estimate.

Our Program Management request, while less than one percent of total program outlays, supports a host of activities. In fact, none of the \$451 billion in Federal program benefit payments could be paid without the activities and projects funded from this discretionary account.

I would now like to discuss briefly the line items that comprise Program Management: Medicare Operations, Federal Administration, Medicare Survey and Certification, Research, Demonstration and Evaluation and, new in FY 2004, the CMS Revitalization Plan.

MEDICARE OPERATIONS

The FY 2004 Medicare Operations request of \$1,776.9 million reflects an increase of \$110.2 million, or 6.6 percent, over the FY 2003 appropriation. This request funds the 50 or so private Medicare contractors who will process and pay 1.1 billion fee-for-service claims, answer 45 million inquiries, process almost 8 million appeals, enroll and educate providers, assist beneficiaries, and carry out other responsibilities on CMS's behalf. In addition, it funds other activities that support these contractors, such as systems maintenance and data communications. It also supports various legislative mandates and Medicare+Choice activities.

We are asking for \$122 million to continue supporting the various activities in our National *Medicare & You* Education Program, including \$12.5 million for the State Health Insurance Assistance Program. In addition, \$35.1 million will be dedicated to the HIPAA administrative simplification and privacy regulation provisions, including \$10 million (and 10 FTEs) to begin HIPAA enforcement activities. We have also placed special emphasis on projects that bolster the Secretary's efforts to move HHS forward in the area of information technology,

including \$53.3 million for HIGLAS and \$14 million to support the Secretary's efforts to modernize and strengthen the Department's systems environment.

FEDERAL ADMINISTRATION

The Federal Administration portion of the Program Management account supports the day-to-day operations of CMS's headquarters, as well as our 10 regional offices. The FY 2004 request of \$580.6 million represents an increase of \$8.8 million, or 1.5 percent, over the FY 2003 appropriation. This line item covers salaries and benefits of CMS's Federal employees as well as information technology costs and operating costs for all of our offices. It includes \$3 million for BIPA section 522 start-up activities, \$3.7 million for HIGLAS, and \$13 million for the Administration's *Healthy Start, Grow Smart* program for mailing 13 months of brochures to new mothers on Medicaid.

MEDICARE SURVEY AND CERTIFICATION

The Medicare Survey and Certification activity ensures that facilities participating in Medicare meet Federal health, safety and program standards. The Medicaid survey and certification counterpart is funded through the grants to States for Medicaid appropriation. Survey and certification activities seek to secure quality services for all Medicare and Medicaid beneficiaries. The FY 2004 Medicare Survey and Certification budget request is \$247.6 million, a decrease of \$5.1 million or 2.0 percent below the FY 2003 appropriation, but equal to our FY 2003 request. This level will allow CMS to continue inspecting long-term care facilities and home health

agencies at the legislatively mandated frequencies. All other provider types will be inspected at the same frequency as in FY 2003. We expect a total of more than 23,000 inspections and almost 48,000 visits in response to complaints.

The FY 2004 budget request includes \$40 million for the Nursing Home Oversight Improvement Program (NHOIP). Of this amount, \$35.2 million will be funded from the Medicare Survey and Certification account and the remaining \$4.8 million will be funded from the Federal Administration account. The NHOIP has been successful at providing training to State surveyors, monitoring abuse prevention efforts, becoming more responsive to complaints, and developing State sanction options. We will continue these current activities and others to ensure that Medicare beneficiaries in nursing homes receive quality care in a safe environment. We have made significant strides in the areas targeted by the NHOIP and we are committed to continue working with residents and their families, advocacy groups, providers, States, and Congress to ensure that residents receive the quality care and protection they deserve.

RESEARCH, DEMONSTRATIONS AND EVALUATIONS

The FY 2004 request for Research, Demonstrations and Evaluations is \$63.4 million, a decrease of \$10.3 million from the FY 2003 appropriation. This request includes \$40 million for Real Choice Systems Change grants, \$3 million for the New Freedom Initiative demonstration activities intended to address workforce shortages of community service direct care workers, and \$20.4 million for a limited

number of new and continuing projects, including the Medicare Current Beneficiary Survey, and projects mandated by recent legislation. Our request is consistent with the Department's plans to streamline research through its Research Coordination Council.

REVITALIZATION PLAN

CMS's FY 2004 request includes \$65 million in two-year money to initiate a new, multi-year investment fund to revitalize CMS systems operations. Previous efforts have been compromised by the competition for limited discretionary budget resources and CMS's growing claims processing and legislative mandate workloads. Designating the CMS Revitalization Plan as a new, separate line item within CMS's Program Management account will ensure that these funds are dedicated to overhauling outdated technologies, policies, and procedures and to the continuing effort to bring the Medicare and Medicaid programs into the 21st Century. In 2004, the revitalization plan will focus on systems-related (information technology) activities. Over half of this first-year request will be used to address known security risks and vulnerabilities, develop systems security plans, and implement an on-going security program. The balance will be used to begin to modernize the Medicare fee-for-service claims processing systems, develop a modern data warehousing environment, and invest in e-gov security infrastructure modernization.

Last, the Administration is proposing user fees to help improve the efficiency of claims and appeals processing. I would like to briefly describe our two user fee proposals for this budget.

USER FEE PROPOSALS

FY 2004 user fee proposals total \$201 million, and include fees for the submission of duplicate or unprocessable claims and a fee for providers who file an appeal with the new qualified independent contractors or QICs. We believe that these user fees are sound policy that will lead to positive change in the Medicare program, if enacted. For example, the duplicate and unprocessable claims fee (\$2.50) will deter providers from submitting time-consuming, wasteful claims. Similarly, the \$50 appeals filing fee will heighten provider awareness of the reformed appeals process and deter frivolous appeals.

Since our FY 2004 request reflects our total funding needs, the enacted user fees would offset our appropriation by the amount of the proposal. We are eager to work with the Subcommittee to ensure that CMS's funding level is sufficient to meet its program responsibilities.

CONCLUSION

Our FY 2004 Program Management request—a 6.6 percent increase above the FY 2003 appropriation—will meet our basic operational needs while supporting the Administration's goals and improving beneficiary education and providing health care choices for our beneficiaries. We believe we can continue to make meaningful changes to the programs we administer within these funding levels.

Thank you for the opportunity to present CMS's FY 2004 budget request. I look forward to working with you, Mr. Regula, and with this Subcommittee, and am happy to respond to any questions or suggestions that you may have.



THOMAS A. SCULLY (Tom Scully)

Administrator Centers for Medicare & Medicaid Services

Tom Scully was confirmed by the United States Senate and was sworn in as the Administrator of the Centers for Medicare & Medicaid Services (CMS) in May 2001. As the Administrator of CMS, Tom serves as the Chief Executive Officer (CEO) of the largest health insurance organization in the world. CMS is responsible for the management of Medicare, Medicaid, the State Children's Health Insurance Program, and other national health care initiatives. CMS's operating budget is larger than the gross domestic product of all but seven nations, and has the largest budget outlay of the Federal Government if the state portion of Medicaid is included. It is directly responsible for \$1 out of every \$3 spent on health care in the United States. The organization insures 28 percent of the population of the United States (almost 82 million beneficiaries), including the elderly, the disabled, and the lowest income individuals in the country. CMS processes over one billion claims each year and it contracts with over one million providers.

Prior to assuming responsibility as the Administrator of CMS, Tom served as President and CEO of the Federation of American Hospitals, the trade association representing the Nation's 1,700 privately owned and managed community hospitals and health systems from January 1995 to May 2001.

Prior to joining the Federation, Tom was a partner in the Washington, D.C. firm of Patton Boggs, LLP. His practice focused on regulatory and legislative work in health care. Before joining the law firm, Tom worked at the White House as Deputy Assistant to the President and Counselor to the Director of the Office of Management and Budget (OMB) from 1992-1993 and as Associate Director of OMB for Human Resources, Veterans and Labor from 1989-1992. In these positions, he oversaw the fiscal policy and regulatory review of the Departments of Health and Human Services, Education, Labor and Veterans Affairs. He also advised President Bush on health care policy, Medicare and Medicaid payment reform.

In 1988, Tom served on the communications staff of the Bush-Quayle campaign and as Deputy Director of Congressional Affairs for the President-Elect's transition team. From 1986-1988, he was an attorney with Akin, Gump, Strauss, Hauer & Feld, LLP. He also worked on Capitol Hill from 1981-1985 as staff assistant to U.S. Senator Slade Gorton (R-WA) and from 1979-1981 at the Federal Election Commission. Tom served on the board of directors of Oxford Health Plans and of DaVita Corporation, two of the Nation's largest health care service providers prior to assuming his position as Administrator of CMS.

Tom holds a juris doctor degree from Catholic University and a bachelor's degree from the University of Virginia.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
BIOGRAPHICAL SKETCH**

NAME: Kerry N. Weems

POSITION: Deputy Assistant Secretary for Budget

BIRTHPLACE: Portales, New Mexico

EDUCATION: B.A., Philosophy, New Mexico State University, 1978
BBA, Management, New Mexico State University, 1978
MBA, University of New Mexico, 1981

EXPERIENCE:

January 24-Present Acting Assistant Secretary for Budget, Technology and Finance

June 2002- Present Deputy Assistant Secretary for Budget, HHS

2001 - 2002 Acting Deputy Assistant Secretary for Budget, HHS

1996 - 2002 Director, Division of Budget Policy, Execution and Management, HHS

1991 - 1996 Chief, Budget Planning Branch, HHS

1988 - 1991 Program Analyst, Office of Budget, HHS

1983 - 1988 Program and Budget Analyst, HHS
(Social Security Administration)

1981 - 1983 Staff Member, United States Senate

HONORS AND AWARDS:

2001 Presidential Rank Award

1995 Secretary's Distinguished Service Award

1993 HHS Senior Management Citation

Mr. REGULA. Thank you. And I will have a number of questions for the record. But just to expedite we will at least hold off for the moment.

Ms. Roybal-Allard.

CALIFORNIA WAIVER

Ms. ROYBAL-ALLARD. Okay. Thank you, Mr. Chairman. And I will submit any questions that I have as well. But I do want to thank Mr. Scully for the tremendous job that he did in helping with resolving the California waiver. I know it was a difficult situation and we really appreciate everything that you and the Secretary did.

As you know, however, we still have some ongoing issues given the fact that we have such a high number of uninsureds in our Nation. In fact, it is probably the number one—L.A. County is probably number one in the Nation with about 2.5 million uninsured out of a total population of 9.5.

One of the issues that was not resolved was the disproportionate share reform proposal, and my understanding is that the State is preparing its proposal and that there has been a commitment by CMS to resolve that issue, hopefully favorably, within 60 days, and I am just wondering if that still is a realistic goal, if you anticipate any problems.

Mr. SCULLY. No. My understanding when we resolved the L.A. County waiver, which I think the Governor was happy with and the Secretary is happy with, it took about a year. It was not always easy but we are glad it worked out well. We couldn't work out the disproportionate share adjustment at the time and I told them as soon as they were ready to talk about it we would work on it. My understanding is that they have not come back and asked me anything yet. But we are talking to Sacramento on coming to me soon. But I made a commitment to work it out. If at all possible we will definitely do that.

Ms. ROYBAL-ALLARD. Okay. Thank you.

Mr. REGULA. Dr. Weldon.

PORTABLE X-RAYS

Dr. WELDON. Thank you, Mr. Chairman and Mr. Scully. I commend all of your employees who are over there in some capacity or in the military and I commend you for bringing up their service to our country in this difficult time. Certainly, I also commend you for the hard work that you do. I often only bring you my complaints and I never, not frequently enough, bring you my commendations. So I appreciate the hard work you do. I know it is a tough job.

Just a couple of quick points. The portable x-ray issue, I continue to feel very strongly that the service that they provide the Medicare system both improves quality and reduces costs, and I appreciate the headway we have made in that arena. I think that entire industry was going to collapse were it not for the interventions that were made. I still think more needs to be done and that the industry is in a precarious state and, having used them, I still feel that they dramatically save a significant amount of money and definitely improve quality.

PRESCRIPTION DRUGS

On the issue of prescription drugs, I would just like to revisit with you in the future a billable service for consulting patients on their prescriptions. I know that is an issue that would be very prone to fraud and abuse, and so any changes in the coding that would allow that would have to be done very, very carefully. But I can just tell you from experience, having practiced in Florida, I had lots and lots of patients move to Florida from the Northeast, Midwest that come in and they typically have complaints related to side effects or costs of their drugs, and I frequently have to spend a lot of time with them to adjust their medication regimens, get them on generics, and I would have made much more money if I saw a little skin tag somewhere and just clipped it off, spent about 20 seconds doing that and quickly sewed it up, or better yet, just froze it so I didn't have to do any type of suturing. And to me, it contributes to cost and it could be a big factor if we create a prescription drug plan. Because most docs, they just fill out the prescription, they hand it to the patient and they don't really care who is going to pay for that drug. In my experience better than 90 percent of the time I could reduce costs, but I didn't get anything out of it.

DEFENSIVE MEDICINE

The other thing I just want to mention, and maybe this is not in your bailiwick, is the issue of defensive medicine. There was a very nice study—you probably heard about it. It came out of the Stanford University School of Economics—looked at the California MICRA reforms and billable services under two diagnostic codes. I think it was unstable angina and myocardial infarction. Showed a dramatic reduction in charges that was not associated with any increase in morbidity or mortality, essentially demonstrating that defensive medicine is real and it is very costly, and when those caps were put in place in California charges under those two diagnostic codes for the Medicare plan declined significantly without any significant increase in morbidity and mortality. The authors of the study went on to extrapolate that the Medicare plan could save billions of dollars.

I know defensive medicine is real. I practiced it every single day in my clinical practice. You think of what they most likely have. You order the test to diagnose that, and then you think of all the other things they could have that you could get sued for and you order tests for all those other things even though you don't think they have that, but you just don't want to get sued. And to me, with the resources that are at your disposal, this is the kind of research that you, or I guess one of your sister agencies, who I believe—are we going to hear from them later? Agency for Healthcare Research Quality. I mean, we should be aggressively studying these things because the authors of the Stanford study claim that this was the first study that showed scientifically that defensive medicine was real. And they extrapolated—and this was published in 1995—that the cost to our health, entire health care system for defensive medicine was \$100 billion a year. I would assume today's economy, 8 years later, that is a \$200 billion a year cost.

I know I threw a lot of things at you quickly. Thank you, Mr. Chairman. I yield back.

Mr. REGULA. It is interesting to get your comment. I think that is a real problem, because I have had friends that they test them to death, you know, and of course it all goes on the bill and I sometimes think that is a fundraiser.

Dr. WELDON. Yeah. I could tell you some really interesting things about this issue and it is definitely a major cost driver, and a lot of people in the Congress feel that medical malpractice is a State issue and it is not a Federal issue, and I have to disagree with them very strongly. We have the fiduciary responsibility for maintaining the solvency of the Medicare plan for senior citizens and we are talking about adding a prescription drug benefit which will be extremely costly. And if you have a nationwide intervention that can save billions and billions of dollars, I think that is very much a Federal issue.

Mr. REGULA. Thank you. For the members that just came in, because we will have the supplemental on the floor once the rule is adopted we have to adjourn. So I am trying to get the two agencies out and finish this thing before we get cut off.

Mrs. Lowey.

Mrs. LOWEY. Thank you very much, Mr. Chairman. I wonder if there is a doctor in the house.

Dr. WELDON. I would be happy to look at you later.

Mrs. LOWEY. I think it is going around, whatever it is. Thank you for appearing before us.

MEDICAID REFORM

The administration's Medicaid reform proposal would essentially block grant the program. Could you please tell the committee what formula CMS would use to determine the base amount of Medicaid funding for participating States under this proposal? For example, do you have any idea or have you calculated how much a State like New York, which is currently spending roughly 39 million of its \$80 million budget on Medicaid would receive?

Mr. SCULLY. Yes. It is an individual grant and I would disagree that it obviously is a block grant. We don't think it is. We basically try to give the States the flexibility to get through a down economic time. What the States came in and asked for was a 2 percent increase in their Federal matching grant. And essentially what we did was we put that amount of money, \$3.2 billion, in to fund it up front.

And it is totally voluntary. Even if the legislation passed, no State would have to do it. New York would only do it if they chose to. New York would essentially build its own baseline based on New York's spending. This is the same thing we do in any State now with a waiver. We have done it with Tennessee, Oregon, and many states. We did it with California very recently. We would say, "What is New York spending over the next 10 years?" To get through this tough time we give them a bump up in the first 3 or 4 or 5 years, and over 10 years it would have to be budget neutral. But it doesn't change who the States can drop. One-third of the people in the Medicaid program are optional populations and two-thirds of the spending is optional, nationally. New York is a little

different. About one-half of the people are optional and that makes up roughly three-quarters of the spending. Any State can drop optional populations any time they like and many States are. And we are very proud of the fact we expanded the Medicaid and the State Children's Health Insurance Program population in the first 2 years by about 2.2 million people. But States are feeling economic squeezes and they are dropping people whether we like it or not.

Mrs. LOWEY. What do they do with those people? Who are they?

Mr. SCULLY. We have expanded coverage. In New York we expanded coverage by over 600,000 people in the last 2 years, and I think that we are happy about that. But obviously States are feeling budget squeezes and they are dropping people. If New York decides to drop Medicaid populations they not only lose the State dollar, they also lose the Federal dollar. So what we essentially said is for the optional populations that they can drop at their will any time they like. We are going to let you keep our dollar. We don't want you to drop your dollar. But if New York has to cut we will let you keep the Federal dollars up front, but over the next 10 years it has got to come out, when the economic times are better, to be roughly the same budget. But we are talking about estimated increases in almost every State of 10 percent a year for the next 10 years.

The Medicaid program, for instance, when I left the government in 1992, I think had a \$34 billion budget. It is now \$310 billion this year. So Medicaid is growing at 10 percent a year. All we basically said is, in tough economic times, to help avoid the States dropping people, we will give you our money up front now. But over the next 10 years maybe your growth rate this year from the Federal Government will be 14 percent instead of 10. But in years 8, 9 and 10 it might have to be 8 percent instead of 10.

So it really is not a block grant. What it basically is is a macro waiver to give the States the opportunity to work through difficult economic times so they won't drop people. It doesn't take one dollar out of the system. It adds a lot of money up front, and basically it is our way of trying to let the States get through the next few years without having to drop people from the Medicaid program, and it definitely does not block grant anything. It basically doesn't affect the mandatory populations at all. New York is still required to cover everybody in the Medicaid program that is a mandatory requirement to be covered. They get funded as they do now for the mandatory program. It only affects optional populations, which the State can drop any time it likes, and unfortunately they are.

Mrs. LOWEY. Unfortunately they are. That is a longer discussion.

Mr. SCULLY. Well, the Governors are in a tough situation and I think their request was to have us come in and just increase. New York's a 50/50 State. The poorest State, Mississippi, is 77/23. New York would like to come in and have us say, "Why don't you give us 52 percent Federal and 48 percent State?" And our concern is that it doesn't cover any more people. It just cashes out a Federal dollar for a State dollar and substitutes for a Federal dollar. And also it would not be temporary. Once those increases happen they never come back. We effectively are doing the same thing, putting exactly the same amount of money in. \$3.2 billion is roughly a 2 percent Federal Medical Assistance Percentage in the first year.

And we are putting in the same amount of money but saying it is not permanent. We are going to do it for the next couple of years to give you the flexibility to work through this time of economic squeeze.

But I would and Secretary Thompson, if he were here, would jump up and down. He is a former Governor. This is largely his idea. We look at it as a way to have the States work through the next couple of years. This is definitely not a block grant.

OUTLIER PAYMENTS

Mrs. LOWEY. Okay. I think I will go on to the next because I have further questions about that one. I understand that Medicare began examining its payment rules last year after the Tenet Health Care Corporation system. I certainly applaud CMS for trying to eliminate fraud and abuse. However, I am concerned that some of the proposed changes punish hospitals that have been good players because, as you know, CMS proposed increasing the eligibility threshold for inpatient outlier payments. And I am concerned that the threshold increase will penalize the very hospitals caring for the costlier sickest patients should CMS reduce the outlier thresholds, so we aren't punishing the hospitals that have been fairly billing Medicare.

Mr. SCULLY. Well, I would agree. I have been a very strong advocate of that position. The outlier thing may sound minor, but it is not. We set aside in the Medicare program about 5 percent of the total paid for inpatient hospital care, or about \$4 billion, for high cost outliers.

Now the system melted down. It wasn't just Tenet Health Care. Tenet was probably the most egregious. They have actually stopped billing us for this. But there are probably 200 to 300 hospitals that were totally gaming the system in a very bad way and I think we are in process of shutting it down. I spent about 2 hours yesterday with the Hospital Association and some of the other groups. I have talked to Ken Rask of the Greater New York Hospital Association. We have a draft rule out there to shut this down. It is the biggest scam I have ever seen in 20 years of working on the Medicare program. I think we are fixing it appropriately. We are going to try to do it without having any inappropriate affects on anybody. But, you know, I have been an advocate of lowering the outlier threshold because if we fix it there the hospitals have been underpaid at the same time. Unfortunately, in 2001, we set aside \$3.6 billion and spent \$5.5 billion. And if you look back at the last 4 years in a row, the taxpayers, without having it allocated in the budget, spent almost \$2 billion a year, \$1.6 to \$2 billion in each of the last 4 years without having it in the budget, and it just kind of went out of the Treasury through these outlier payments and we didn't understand it.

So from OMB's perspective, and I am now at least temporarily on their side, it turned out even though we fixed the rules for the first half of this year we are way over budget, and at least for this year I am afraid we are not going to be able to drop the outliers and I think I am probably on the side of OMB of keeping it where it is until we figure out how this works. If we can fix the rules and get the system back on track where the right people are getting the

right payments, I would expect hopefully next year there will be an adjustment that will compensate the hospitals that should be getting paid the right amounts. But right now for this year we are supposed to spend 5.1 percent of our budget on hospital outliers, which is about \$4 billion, and we are way, way over budget, unfortunately, for the last 3 or 4 years. So this system is still very broken, but we are trying fix it.

Mrs. LOWEY. Thank you. Thank you, Mr. Chairman.

Mr. REGULA. You didn't get a chance maybe to respond to what Dr. Weldon said about—do you want to take a minute and just give him your commentary? Oh, I am sorry, he is gone.

PORTABLE X-RAYS

Mr. SCULLY. Well, I agree 100 percent with the malpractice and I will just compliment he and Mr. Manzullo both for getting our attention on portable x-ray supplies. We spent a lot of time fixing that. I think the rates in the last year, due to his attention, have gone up about 30 percent, 26 percent in Florida. And I think that it has gotten us to focus on it a lot and I think in many cases they were underpaid and his attention has definitely gotten ours and worked much for the better. I was just complimenting you, Dr. Weldon, and Chairman Manzullo's efforts on portable x-ray supplies, and I think we may have more work to do but you have gotten our attention. I think the payment is more equitable and fair as a result of that.

Dr. WELDON. Thank you.

Mr. REGULA. Mr. Cunningham.

Mr. CUNNINGHAM. Thank you, Mr. Chairman. Thank you, Tom. Who says lawyers aren't good arm wrestlers?

CLINICAL QUALITY CONTROL REGULATIONS

I want to thank you for the meeting yesterday on cardiodynamics and the willingness to work with the doctors. I think it is really, really important. I have got two companies in my district, BioSIGHT and Quidel. They have got a little diagnostic test like this for strep and it has a built-in quality control in here. And they were concerned about some recent regulations written by CMS and the severe guidelines that haven't been published yet. And they were concerned that since they already have the control built into the thing, will it satisfy the quality control regulations by CMS?

You can provide it for the record if you don't have it right off the top of your head on this one.

[The information follows:]

CLIA DRAFT SURVEYOR GUIDELINES FOR NEW STANDARDS

The "draft" Surveyor Guidelines have been released for review and feedback to experts in the laboratory community, manufacturers, professional organizations, and State and Regional CLIA consultants. Once this feedback has been received and evaluated, we anticipate a fall publication date for the guidelines. The guidelines will also appear on our CLIA web site.

Mr. SCULLY. I tried to figure this out this morning because I knew you were going to ask. I have to find out, but I would be happy to meet with them and talk with them. We have some regs on the Clinical Laboratory Improvement Amendments of 1988

(CLIA) coming out, I think, this fall, and I think it is unclear how they would be affected.

[The information follows:]

CLIA QUALITY CONTROL MECHANISMS UNDER NEW RULE

The use of "internal" or "built-in" controls is dependent on whether these controls meet or exceed the requirements now at 42 CFR Part 493.1256(d)(3). In the event they meet or exceed the new requirements, the laboratories must follow manufacturer's instructions. A laboratory's decision to use test systems with "internal" or "built-in" controls is contingent upon the quality system the laboratory uses to ensure and improve the accuracy of testing and whether these controls monitor the precision and accuracy of the complete analytical process.

Mr. CUNNINGHAM. Yes, sir. They were wondering if it was going to be covered by CLIA regulations since you already had the quality control test built in with the unit itself. Crescent Healthcare also provides an intravenous immunoglobulin injection, and it costs \$10,000 per time and they have to do it once a month. If you would look at the particular disease, I mean, you would turn your head away it is so terrible. But when you administer this treatment it goes away. I mean you don't even know they have the disease. And it is covered in a hospital. I think if you look at some of these patients that have this disease, I wouldn't even know how to describe it, with the skin. But some of them it is very, very difficult for them to get into the hospital just because of the disease itself. And this product is not covered in home, which would actually be cheaper to do it in home. And again if you could just look at that and maybe provide for the record.

Mr. SCULLY. That really comes to the heart of the whole prescription drug debate. This year, as you know, we spent about \$7 billion on physician-administered drugs in Medicare. But we only cover them in the hospital and the doctor's office, and we don't cover obviously anything you buy in a pharmacy. We only cover drugs that are not usually self administrable, and that is the whole issue. We only cover drugs that are done and infused in a doctor's office or in a hospital, and this is exactly the issue. We will pay for it if you are in a doctor's office or a hospital, but you can't have it done at home.

And there are many examples of this. I have rheumatoid arthritis. There are two drugs that are very similar. We pay for the one that is done in a doctor's office. The one that is done at home, we don't. And that is one of the key issues. Once you expand beyond the doctor's office and the hospital you go from \$7 billion to probably \$70 or \$80 billion a year spending, and that is the whole issue about the coverage of prescription drugs, which I think includes the blood products and I think the immunoglobulin falls into that category since it is considered a drug type product.

Mr. CUNNINGHAM. Yes. And California has got, my colleague discussed, you know, tremendous problems right now. There is a \$35 billion debt. I mean that is like a national debt and education is being cut, MediCal, all the different things, and we have a large population. About one-half of the children born in California hospitals are to illegals. We have got 22,000 illegals in our prison system, which have to be administered, and they of course show up for health care in emergency services. So it is really taxing California and I don't know how we are going to unbury ourselves. But

we have got a tremendous problem there and I think if you can take a look at it.

Mr. SCULLY. I spent a lot of time due to the L.A. waiver with Governor Davis and the Secretary of Health.

Mr. CUNNINGHAM. I want to thank you for that. I want to tell you when Governor Davis held off buying energy and he bought it up high, that delta, between buying high and selling low, is \$10 billion that is coming out of our school systems and Medicare. So we do have a problem.

Mr. SCULLY. Well, we try to be helpful to California, the chairman of the Rules Committee, and Ms. Harman, who I just saw outside, and many other people in the California delegation that we work closely with. You know you have got a massive problem in California.

Mr. CUNNINGHAM. And we thank you for that, sir.

Mr. SCULLY. But I think we have done our share at least to help a little bit.

Mr. CUNNINGHAM. Thank you, Administrator Scully.

Mr. REGULA. Mr. Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman. Welcome, Mr. Scully. It is good to see you again. I had a couple of questions for you, one in relation to Mrs. Lowey's question earlier about the nature of the block grant which you reject was a block grant but which still raises some questions for us in terms of what is going to guarantee the safety net coverage for people if States do opt into this approach of managing Medicaid funds.

I want to get a couple of my questions in. So that would be the first one. If you could just comment briefly about what may be some prospects for risks, the risks that you see in this new approach. It has got to have risks involved and it would be nice to hear what you perceive the risks are yourself.

Two, Rhode Island has a couple of waivers that we are waiting on. One is the Medicare prescription drug waiver and that has been applied for and we are still waiting on that. Anything we can do to help move that along or see where you are in the process, and also the State prescription drug RIPAY program has a waiver that is pending, terms of eligibility for purchasing reduced prescription drugs through the RIPAY program, which you know is a waiver in itself for the Medicaid, which I like and I would much prefer. I told Secretary Thompson that I would much prefer to see waivers when it comes to Medicaid than have a wholesale upending of Medicaid through this new proposal that you have.

So that would be part two. And then finally, you know, if I do get a chance I wanted to give your attention to something kind of much different from both of that. I asked for a GAO report on States where families had to give up custody of their children in order for their children to get the services they needed, and that preliminary GAO report is striking in the extensiveness to which parents have to give up custody of their children to ensure their children receive appropriate treatment for mental illness. But then the parents are locked out of any treatment decisions that are made on the part of their children, and that seems to me disjointed and against our whole concept of family values and wanting to keep families an integral part of their children's lives.

I know we have problems where parents don't want to be associated with their children's lives. These are parents who do want to be part of their children's lives, but because it is so prohibitive for them to get private insurance and it is really not there for their severe disability—the kids that are suffering from mental illness disability, they have to turn those kids and relinquish custody of those kids to the States.

So those would be my top three, and I would have others for a second round of questions.

Mr. REGULA. Okay.

MEDICAID WAIVERS

Mr. SCULLY. Well, we talked a lot about mental illness in the past. There is an unending level of problems with Medicaid and Medicare there. Let me start with risk. I don't think it is a block grant obviously. We have tried to find a way for the States to give flexibility. Governor Bredesen, the new Governor of Tennessee, has extensive experience in health care. He spent time going through this and what the options were. What he found, and what I think you would find, is that basically the structure of this is almost identical to TennCare already and what Oregon has done. So essentially it is a waiver very similar to the two most creative waivers in the country, probably Oregon and Tennessee, and the financing of this is very, very similar. The major difference is that you are required to protect the mandates. The mandatory populations of Medicaid have to be covered. This can't be changed. The funding remains the same. The statutes requiring states to cover mandatory populations are all exactly as is. This really only affects optionals.

Are there risks? I think there are risks, but just like there are in Oregon and Tennessee, you basically have to come up with a multiyear baseline on your own. So if you were in Rhode Island you come in and say this is what we expect in the next 10 years with population growth and other things. This is how we expect it to go over the next 10 years. We would like a little more money up front and we want more flexibility to be creative in how we are running our optional programs.

But no Governor has to do it. Even if our proposal passed, it is purely optional. The only reason we need legislative authority is to put a little more money up front. We could do almost all of this by waiver. You know, if I were on the Commerce Committee, I would probably write in the talking points that it is a block grant, and I understand that, but I don't think it is. I think that when Governors look at it they will find that it is going to give them a lot of flexibility. If they don't want to do it they don't have to. We are just trying to help them work through the next couple of years.

Mr. KENNEDY. So now how about our waivers?

Mr. SCULLY. On your waivers, I think I signed one last night, but I don't think it was one of these two from Rhode Island.

Mr. KENNEDY. Well, maybe tomorrow night.

Mr. SCULLY. On the issue of Medicare, I will look at it and call you back today. I think the issue on the bigger one the Rhode Island waiver, is a big problem in Pennsylvania, New Jersey, and a lot of States that already have programs where they cover drugs

for seniors. They are 100 percent State-funded programs. And our problem is that we can't go in and basically buy out the base of those States. In other words, if you get a 100 percent State-funded program in Rhode Island up to a certain level, a lot of States come up with waivers and say, "We would like you to turn in the Medicaid program and pay us for half of it." We just haven't been able to do that. Under the budget, that is not a waiver.

One of the things that a lot of people haven't been focused on, under the President's framework and also under most of the major Medicare reform proposals whether Senator Gramm's or Mr. Thomas or whoever, is that almost all the States that have existing programs like Rhode Island, New Jersey, New York, and Pennsylvania would have an enormous benefit. The Federal Government would be buying out a lot of the State-only drug programs. So you would be taking a lot of the pressure off Rhode Island, Connecticut, New York, and New Jersey. All the States should be for a Medicare prescription drug benefit because every one of those that has done more than Medicaid is going to get a significant amount of their State programs bought out under the President's program or plan.

I can tell you we are buying out very big chunks of Medicaid and State funded drug benefits for seniors, so there would be a significant economic benefit to Rhode Island, Connecticut, and New York, probably about half the States. So while many States are coming in for waivers and asking us to do that under current law, what the Secretary has done under current law is to take money we would be spending any way and readjust it. We can't appropriate billions of dollars. We don't have the authority. So we don't have the ability to buy out State spending now. But I think under most of these legislative proposals you would find that States like Rhode Island would be big net winners.

Mr. KENNEDY. Well, Mr. Chairman, I have a Columbus Dispatch here that I want to enter into the record for——

Mr. REGULA. Without objection.

[The information follows:]

07/21/2007 2:18 PM

from being hyperactive at age 5 to out of control by 11.

Haunting them during the decision was a warning by an Ohio State University Medical Center doctor who said that if they didn't do something soon, Bryan wouldn't live to see his 18th birthday. They chose to help him by giving him a big hug and a kiss and explaining that they always would be his parents, in their hearts if not on paper.

Guilt and shame

By giving up custody, Southern said, caring parents are deprived of the authority to make medical, educational and other important decisions for their children and to raise them in ways consistent with their values and ideals. They also endure guilt and shame and often the castigation of neighbors and friends who label them as cold, unloving parents.

If they don't give up custody, they face the all-too-real risk that their families will fall apart. And they could be taken to court for not obtaining proper care for their children. That happened to Jan Durfee, a 47-year-old single mother of three.

The Cuyahoga Falls woman is fighting to regain custody of her 9-year-old son, Zac, who was removed from her northeastern Ohio home in February after she called a caseworker to complain that she had lost a child-support battle and didn't know how she'd be able to continue to care for her sons.

"I was just stressed out that day," Durfee said. "I love my son and will do anything to get him back."

Like many other children with serious mental illnesses, Zac has multiple diagnoses -- severe bipolar, Asperger's syndrome and obsessive-compulsive disorder -- and has been labeled a "diagnostic puzzle" by his doctor. He has been on more than 30 medications in dozens of combinations and has become more aggressive through the years. He hits, kicks and bites and has hurt his mother frequently.

Her income -- a \$527.50 monthly disability check because she has fibromyalgia, a condition characterized by body pain and severe fatigue, plus \$64.50 in child-support for one of her three sons -- is low enough to qualify Zac for Medicaid. But the publicly funded services are insufficient and unavailable, she said.

Besides losing their children, Southern said, many families who give up custody are required to pay the state for part of the care -- much like child support in a divorce. Children Services wanted the Dvorskys to pay \$700 a month, but a domestic-relations judge dropped it to \$450 after they proved that the higher amount would strain Mr. Dvorsky's salary as a Battelle engineer.

And more often than not, Southern said, the child is put in foster care or a residential treatment center far from home because such places are few and far between.

"The irony of it all is that the foster parents get the very support and services denied the child's parents," she said. "Go figure!"

Can't afford treatment

State and federal governments do not track the number of parents relinquishing custody solely to obtain mental-health services. But a survey by the National Alliance for the Mentally Ill determined that one in five families with severely mentally ill children gave them up in 1998 because they couldn't afford treatment.

The surgeon general reported that about 11 percent of youths ages 9 to 17 -- about 4 million children -- had a major mental illness in 2000 and that as many more had less-serious mental-health problems.

With more than 500,000 children in foster care, some people question the logic of straining the child-welfare system by adding mentally ill children who already have loving, dedicated and nonabusive parents.

"It's a needless tragedy," said Terry Russell, executive director of the National Alliance for the Mentally Ill in Ohio.

No federal law exists that entitles children to mental-health services. There also is no single source of funding, federal or state, for the services; and many insurance policies do not cover physical and mental illnesses equally. Thirty-four states have laws requiring some form of mental-health parity. But Ohio is not one of them.

In addition, qualifying for Medicaid has become more difficult, Russell said, and the federal government has reduced the number of mental-health services considered medically necessary under the program.

"There are few children that are on Medicaid for mental-health reasons who aren't wards of the state," he said.

Even when a child receives Medicaid, Russell said, many doctors, psychologists and psychiatrists won't accept it.

"Who has the money should be the last consideration when helping a child with a mental-health crisis, but the system is ass backwards," said Cheri L. Walter, chief executive director of the Ohio Association of County Behavioral Health Authorities.

The Dvorskys' insurance provides minimal mental-health coverage, including a limited number of hospitalizations and therapy visits, and a cap on money available for residential treatment. They quickly exhausted coverage and ran thousands of dollars into debt.

Meanwhile, their son's behavior continued to spiral out of control -- from tantrums to stealing to running away to more-recent inappropriate touching of girls, including the buttocks of a 4-year-old family friend.

Mr. and Mrs. Dvorsky were holding on to their sanity by a thread and were concerned not only about Bryan but also about Melissa, who dealt with her own bout of depression because of the stress.

"My son is a good boy," Mrs. Dvorsky said. "He never asked to be mentally ill."

Funds difficult to find

Arthur and Tracy Thatcher of Reynoldsburg have allowed Fairfield County Children Services to put their 9-year-old daughter, Racheal, in a foster home in hopes of getting care for her, but they refuse to give up guardianship.

"We're her parents and consequently know what's best for her," said Mrs. Thatcher, 29, who herself has been manic-depressive her entire life.

The agreement has allowed the Thatchers to stay involved in making decisions for Racheal, while giving them a break from caring for her, but they're still squabbling over who is going to pay for treatment. In the seven weeks since leaving home, their daughter hasn't been able to see a counselor or refill medication.

Racheal has attention-deficit hyperactivity, bipolar and oppositional-defiant disorders and is obsessive-compulsive to the point that she picks scabs and sores until they bleed. She has frequent emotional breakdowns and mood swings and has threatened to kill herself by jumping off a roof or strangling herself.

Intense therapy in hospitals and residential treatment centers has helped, but at \$350 a night, it is expensive. Such treatment can include 24-hour nursing care, family counseling and visits by child psychiatrists, social workers and art and music therapists.

A pilot for Airborne Express, Mr. Thatcher, 36, has exhausted his sick time and 90 days of family leave

and has lost close to half his salary. He juggles household expenses and \$700 a month worth of medication and psychological visits for his daughter while chipping away at a \$20,000 debt for her three-month stay at a Dayton psychiatric hospital. The Thatchers also have two sons -- Devin, 4, and Dylan, 1.

"America is supposed to be the greatest country in the world," Mrs. Thatcher said. "But how can it be when mental illness is taken so lightly?"

There is hope.

Nearly a dozen states have enacted laws saving parents from being forced to give up custody of their children to get mental-health treatment, according to the nonprofit Judge David L. Bazelon Center for Mental Health Law in Washington. Seven use a voluntary agreement that allows them to pay for out-of-home placement without taking legal custody. Ohio has voluntary placement but for only 30 days -- too short to help children with severe problems.

Although no legislation has been proposed in Ohio, many organizations, including the state departments of mental health and education, the Ohio chapter of the National Alliance for the Mentally Ill and legal-rights advocates, met in December to try to get their hands around the problem.

"No parents should ever have to give up their children to get mental-health care. Period!" said Sam Hibbs, spokesman for the Ohio Department of Mental Health.

Possible federal solution

Perhaps most promising is the proposed federal Family Opportunity Act. On July 11, the Senate Finance Committee approved the act, which would allow families with severely disabled children to buy into Medicaid while continuing to work.

Under the proposal, first introduced in 1999, parents with incomes up to 250 percent of the federal poverty level -- \$45,000 a year for a family of four -- could pay for Medicaid coverage on a sliding scale.

But the bill faces hurdles. The full Senate must consider it, and some lawmakers already have balked at its price tag of \$5.7 billion over 10 years.

Closer to home, House Bill 33 in the General Assembly would prohibit health-insurance companies from discriminating against treatment for mental illness or substance abuse.

"That we force people into giving up their kids or going onto public assistance is one of the state's great tragedies," said state Rep. Lynn E. Olman, the bill's author.

Opponents say insurance parity would be too costly. But Olman, a Republican from Maumee, said an independent review shows it would result in an average increase of only 1 percent to 1.5 percent in health-insurance premiums.

"It makes no sense that you're covered if you get hit in the head and suffer brain damage but not if you have chemical imbalance of the brain," he said.

But there is little likelihood of passing such a bill at a time when stock prices, tax revenues and retirement funds all are dropping, he said. "I don't hold out much hope."

Until more is done, youngsters such as Bryan Dvorsky will continue to feel angry, abandoned and alone.

"Being given up by your parents just adds insult to injury to children who already have been labeled and treated their entire lives as 'bad kids,'" Mrs. Dvorsky said. "It breaks my heart."

epyle@dispatch.com

Caption: (1) ALYSIA PEYTON | DISPATCH

Tracy Thatcher, of Reynoldsburg, enjoys a visit with her daughter, Racheal, 9. The girl is living in a foster home in order to qualify for medical care.

(2) In order to get mental-health treatment for Bryan Dvorsky, above, at Buckeye Ranch in Grove City, his parents, Renee and Jim, left, had to relinquish custody. They could not afford the \$450-a-day fee.

(3) Brian Dvorsky

[Back to Search Results](#)

All content herein is © 2002 The Columbus Dispatch and may not be republished without permission.

Mr. KENNEDY [continuing]. About the families facing the trade-off of getting their kids the treatment they need by relinquishing custody of them. Basically they have to say they are abusing their own children or the kids are, you know, doing something illegal. You know, this is the only way, and I was wondering if you could comment and what we are going to do to help the States.

Mr. REGULA. Why don't we save that for the second round if we have one, because we are on a tight constriction of the supplemental being on the floor.

Mr. KENNEDY. Oh, okay.

Mr. REGULA. Mr. Sherwood.

OUTLIER PAYMENTS

Mr. SHERWOOD. Thank you, Mr. Chairman, and welcome, Director Scully. I have several things I would like to submit for the record. I am very pleased that your group has ferreted out the outlier issue, but I am very concerned that you have taken the tack that you are going to let the people who are gaming the system down easy at the expense of the hospitals that weren't gaming the system.

Wyoming Valley Healthcare tells me that under your new rules they will lose 1.2 to \$1.5 million a year and they weren't doing anything wrong. How can we justify penalizing the hospitals that were playing by the rules by letting the ones who were gaming the system down easy?

Mr. SCULLY. Well, I am with you. A lot of people have asked me to let the ones who were gaming the system down easily. I affirmatively have not. One for example is Tenet Healthcare. Even before this rule, they have foregone hundreds of millions of what they still could be doing as far as of January 1st.

I had Temple Hospital in yesterday and a lot other hospitals that had high outliers and were not arguably gaming the system. I think I have been extremely tough on them, tougher than some people would like. But it is only in the draft rule we put out, and the comment period closes I think in 3 days, that I have become aware that inadvertently we may in fact be hitting some people. I will be happy to talk to the CEO of your hospital if you would like. By changing a couple of the rules, we may also be inadvertently hitting people that weren't doing anything wrong. I hope we are going to fix that in the final rule.

But you know we are very sensitive. This is big dollars for hospitals. It is almost \$2 billion that have been inappropriately allocated per year to the wrong hospitals and to the wrong places. I am trying to fix it without being unusually cruel. It is the worst thing I have seen in the Medicare program ever.

WAGE INDEX

Mr. SHERWOOD. But I couldn't be more pleased with your answer and I would love to have you speak with Dr. Bell Holst and we will get that set up. As you know, in my area, I still have problems with the wage index. I have hospitals that compete right next door with people that are 30 percent higher. And so we are interested. There is a new bill that would reduce the impact of the wage index

on the formula, and I think that might be a way out and I would be interested in your comments on that.

Mr. SCULLY. The wage index is unbelievably complicated. I can tell you that Secretary Thompson is totally with you. He is from a relatively rural State. Every time I look at a rule, and we are about to do next year's hospital and physician rules, there are many ways—it is unbelievably complicated—that we can administratively do this and we are trying to do the best we can. But I also think there is going to be quite a legislative debate, especially with the Senate side this year, on making adjustments to the wage index. Some of the things are not fair. Some of the things that happened in Pennsylvania obviously are due to other adjustments which we have discussed. But we were committed to making the wage index fair for hospitals and the Geographic Practice Cost Index (GPCI), which is the equivalent for physicians, fair as well. It probably won't get to the point where rural Pennsylvania is the same as Philadelphia or Pittsburgh, but I think there are ways to adjust to make it fair.

Mr. SHERWOOD. And we don't think we should be the same. But when you are right next to one that is paid 30 percent, figured on a 30 percent higher formula, it makes it very difficult to compete.

Mr. SCULLY. Well, unfortunately what happened in Scranton/Wilkes-Barre, as we have discussed it, is that legislatively western Pennsylvania, about a 2-hour drive from New York, has been legislated into New York so they get a wage index of New York. This is also probably not rational. Some of the counties in Pennsylvania have been legislated almost as far up as Phildepphia. So Scranton/Wilkes-Barre not only has the problem of having a wage index .57 points below New York but they are surrounded by counties that have artificially high wage indices that probably shouldn't.

So the right answer theoretically would be to rebase them all and give them the right wage index. But a lot of this is due to legislative gerrymandering over the years as well.

MALPRACTICE REFORM

Mr. SHERWOOD. Well, we understand it is complicated and we need a solution. The other thing that I would just like to touch on, I am afraid with the malpractice crisis that we have going on we are taking a great step backward in rural health care. I have many small rural hospitals, not too small either, who are going out of the obstetrics business because—and we are going to go back to where we were in the 1930s of not having a hospital that will deliver babies in the immediate area. And with all the great progress we have made, anything that, I think that is an issue that we need to bring to—and I don't expect you to solve it here at the hearing, but I wanted to bring it up.

Mr. SCULLY. I don't think the administration could solve it. Pennsylvania probably has as bad a problem as any place in the country with malpractice. Dr. Weldon asked about this. I think we are pretty aggressively for malpractice reform, that there is no question in my mind that the Medical Injury Compensation Reform Act (MICRA) in California has worked pretty well. You can argue about the levels of the caps but it is hard to argue that it has caused patient harm in California. I personally think that there is

no argument against malpractice reform. But I also think that we should, and we have, pushed very hard to tie in patient quality. We are trying to measure quality in nursing homes and home health agencies and hospitals. I think it will make even a better argument for malpractice reform if you can measure quality, show that hospitals, doctors, nursing homes are improving quality so that this really isn't about patient care. But if we can measure and show improvements that we have had, we can show that we are protecting patients appropriately and there will be a lot more support, as there should be, for malpractice reform. We just put out a study last month that showed significant improvement in patient care for Medicare patients since 1998. Your obstetrics problem is exactly right. That is an enormous problem, especially in some States. Pennsylvania has probably as bad a problem as exists in the country right now.

PREScription DRUG SPENDING

Mr. SHERWOOD. Thank you. I would just like to go back to one comment you made. You said you are now paying \$6.5 billion annually for prescription drugs and if we provided a prescription drug benefit under Medicare it would raise it to \$80 billion a year. Did I hear that right?

Mr. SCULLY. Well, that is the additional spending. But most of the prescription drug benefits, and they obviously differ between what the administration, Mr. Thomas, Senator Gramm, and others propose, probably cover less than half the seniors' benefits. But if you look at the mid-range of additional costs a year for most of these benefits, we have obviously budgeted \$400 billion over 10 years. You are talking \$30 to \$40 billion a year of additional spending, but that only covers usually half of the prescription drug spending for a senior. Right now all we cover is drugs in the hospital, in the doctor's office and in a hospital outpatient center. We don't cover anything you buy at a Walgreens or CVS.

Mr. SHERWOOD. Well, what was your \$80 billion figure?

Mr. SCULLY. That is the total spending roughly. If you are spending \$30 or \$40 billion more for a prescription drug benefit for seniors, that is what Medicare would be covering under most proposals. But that is only a fraction of what seniors actually spend. What I am saying is the total spending for seniors a year for of all their prescription drugs is more like \$80 billion. Nobody is talking about covering all of it.

Mr. SHERWOOD. Thank you very much.

Mr. REGULA. Mr. Peterson.

OUTLIER PAYMENTS

Mr. PETERSON. Thank you and good morning. I think you just misspoke. I wanted to see if I heard you right. You said much of western Pennsylvania has been hooked onto New York City for house call rates.

Mr. SCULLY. I meant Western New York, I am sorry. Many counties a long drive west of New York were legislated in New York. So the problem with Scranton/Wilkes-Barre is that they look north and see in these very rural counties in New York a New York City

wage base, and they are competing for nurses, for people that get paid twice as much.

Mr. PETERSON. Southern New York State rural hospitals are healthier than mine. Now I know why.

Mr. SCULLY. It depends on the county.

Mr. PETERSON. I represent rural. I think the most fragile part of our health care system is rural. What is your assessment of the health of rural health care?

Mr. SCULLY. I think it depends on the State and on what they pay in Medicaid. It depends on what the makeup of the county is for Medicare. But I think, generally, our view is that there is no question that, on a relative basis, the margins for rural hospitals and rural health care are lower. If there is a place for Congress to make adjustments, it is probably in rural areas. Some of it can be done within the existing spending levels, we believe.

HOME HEALTH CARE

Mr. PETERSON. I am pleased to hear you say that because we are not doing as well in the House as I would like to be doing. I am very frustrated because in home health, with the current 15 percent cut that was inflicted in October, and the 10 percent add-on that just ran out, that is a 25 percent reduction in home health payments and our system was fragile to begin with because when they squeezed the system it was squeezed equally. And the parts of the country that were abusing the system certainly ended up healthier than the parts of the country that were not. Most of home health in Pennsylvania and New England States was done by the visiting nurses who raised a lot of local money and who did a lot of free care and were not fat and wasteful. And as a result of getting squeezed, I have home health care agencies that are still paying off debts. And the only reason they stayed in business was they borrowed money for a number of years since 1996 and this 25 percent reduction in payment I think can put a lot of them out of business.

Mr. SCULLY. Well, home health spending actually went up 26 percent last year. It is a 25 percent reduction in spending theoretically per day, but we basically went to a system where we pay them for a 60-day period. Instead of paying them every day for every visit, we pay them for a 60-day period. We went to a prospective payment system 2 years ago and the number of visits per 60 days, as you would expect, dropped. There is no evidence the care has gone down. But total spending has gone up about 26 percent. If you want a microcosm of how dominant the Medicare program is, home health for the last 15 years would be a pretty good one. We were spending \$3 billion a year on home health in 1990. We went from \$3 billion to \$18 billion in 1996, and it was totally out of control. Congress made cuts. It went back down to 9 billion in 2 years and now it is going back up again. We probably would have been a lot better off without the big ups and downs. I would be happy to come spend time with you and there are certainly places, especially rural and frontier areas, that have problems with home health payments. But I believe the home health business is again relatively healthy. They had some very tough years in 1997 and

1998. I think the payments are fair and they are growing very, very fast.

FASTEST GROWING COST ITEMS

Mr. PETERSON. Well, we will talk about that another day. What is your fastest growing cost item?

Mr. SCULLY. Self-administered drugs, in Medicare grew 26 percent last year. The second biggest is probably home health and that is actually within the last half of the year. That is about 26 percent last year. Durable medical equipment, including wheelchairs, went up 20 percent last year. That is not due to more people, that is just a lot of strange things going on that we are looking at. Inpatient hospital spending, which is our big item, went up 9.8 percent last year. It was supposed to go up 4 percent. The Medicare program, this was in my original statement which I skipped, is out of control. We have big problems in the Medicare program. It has grown much faster than everybody expected.

Mr. PETERSON. How many prescriptions did \$6.5 billion buy?

Mr. SCULLY. We don't actually pay for prescriptions. The doctor has to infuse it in the hospital or in the outpatient clinic.

Mr. PETERSON. So you don't really know what it costs per patient.

Mr. SCULLY. It is very expensive. I mean our biggest selling drug is Procrit, which is a cancer red blood cell drug. It is the highest cost, we spend \$1,122 every 2 weeks on each patient.

PRESCRIPTION DRUGS

Mr. PETERSON. Do you agree with me that—and I am not talking about cancer drugs and blood thinners and things that are life essential, but aren't we becoming an overmedicated society, overdependent on medications and prescription drugs for our health?

Mr. SCULLY. In some ways it is good because it probably keeps people healthier if you have a doctor who is overseeing and prescribing them. Many seniors have way too many prescriptions and they are not particularly well coordinated. Sometimes they are buying extremely expensive drugs like Vioxx and Celebrex when Motrin would do. I can pick on lots of these things. I think prescription drugs, in many cases, help people's health and are great. But in other cases they are buying the wrong drugs, too many drugs, and wrongly-prescribed drugs. We need to coordinate it better and make it more efficient.

Mr. PETERSON. But when you have people on 10 to 20 drugs, I can't think that is healthy. I hear people tell me all the time that they went to their physician, took their parents off of all of these drugs, went down to three or four and they are much healthier.

Mr. SCULLY. We have 250 million people in this country under the age of 65. If you find everybody in the country that has prescription drug coverage through a pharmacy benefit manager, they generally get notifications about too many prescriptions and interactions, and they get a little more coaching and a little more patient information. Rarely do seniors get that.

One of the things that will actually help, we think, when you get the senior prescription drug benefit is that you will actually have, like we do, companies like Express Script's and Advance PCS, occa-

sionally calling you or sending you a note saying these two drugs don't interact well. There are a lot of benefits. Seniors generally have the worst coordinated care when it comes to prescription drugs, which is also a problem.

MEDICAID COSTS

Mr. PETERSON. You talked about skyrocketing Medicaid. I was in the Pennsylvania State Senate for a number of years where I chaired health for 10 years. When I left the State Senate they still did not know what they were paying for. I went to a Medicaid conference and raised the issue. They told me there were probably only two or three States—that has been a few years, 7 or 8 years ago—that actually had a handle on what they were paying for. To make Medicaid decisions in Pennsylvania we never could get data on what we were paying for. They didn't have concise data in this day and age.

Are States doing better? Do you know what they are paying for?

Mr. SCULLY. I wish I could tell you what it was paying for in Medicare. I think that is one of our concerns about running a giant insurance company. What most of the States have done, which a lot of people don't realize, is that 24 million Medicaid beneficiaries are now in private health plans, Medicaid plans. Medicaid "managed care" is basically taking over Medicaid for exactly that reason. States were running big insurance plans like I run Medicare. They basically found over the years that it was more efficient, more cost effective, and better management if they started hiring, as Pennsylvania has done almost statewide, Medicaid managed care plans to manage their Medicaid populations better, and in most States it has worked very well.

Mr. PETERSON. Well, it never reached the rural areas.

Mr. SCULLY. But in most of the urban areas it has. In rural areas, it is much tougher.

Mr. PETERSON. Thank you.

Mr. REGULA. I would say to the members we expect a vote in about 25, 30 minutes and then when we go to the floor the bill on supplemental. We will have to be adjourned. So I think what we are going to do is get the Agency for Healthcare Research Quality on this morning, and that is probably going to pretty much exhaust us as far as time. If you will submit your questions for the record. I know I have several here, and that is what I will do.

FRAUD, WASTE, AND ABUSE

I just want to ask one question, and that is we hear a lot about fraud, waste and abuse. Does your agency work at that? Is that as big a problem as people would allege that it is?

Mr. SCULLY. It depends on how you measure it. We have cut the error rate in half in the last 7 years in Medicare, and I think we work very well with the Inspector General of the Justice Department. I think there is a delicate balance between being extremely aggressive on fraud, which we have been the last couple of years, and the complaints you probably hear from your doctors and hospital administrators about somebody in the government threatening them. I hope we have found the right balance. But when you are running \$592 billion of programs like Medicare and Medicaid,

there are always going to be people cheating on the margins and getting money out of the programs.

Mr. REGULA. But you are working at it?

Mr. SCULLY. It is a never-ending fight and I am very aggressively working on it.

Mr. REGULA. Okay. Well, thank you very much for coming. I am sorry we have to cut short, but that is the way the rules work.

Mr. SCULLY. Thank you, Mr. Chairman.

[The following questions were submitted to be answered for the record:]

SKILLED NURSING FACILITIES

Mr. Regula: We understand that CMS has proposed a rule to expand the application of the 30 percent reduction in bad debt reimbursement for hospitals to skilled nursing facilities (SNFs), with the goal of giving nursing facilities an incentive to collect bad debt. Many nursing home patients are dual eligibles and the obligation for unpaid coinsurance and deductibles shifts to state Medicaid programs. However, we understand that CMS has provided States like Ohio and Pennsylvania with an option to shield themselves from this obligation under Medicaid.

Mr. Scully: As you mentioned, CMS is in the process of completing work on a regulation related to bad debt reimbursement for SNFs. We take seriously the comments received on the rule as we decide the policies that will be implemented. Once the rule has been issued, we would be more than willing to provide the particulars to the Committee.

Mr. Regula: SNFs have already had to absorb a 10 percent cut in Medicare funding that took effect last October. In addition, most States have made or are considering cuts in their Medicaid programs, including the elimination of this obligation to reimburse SNFs for lost Medicare co-payments. Given these circumstances, can we expect SNFs to increase their collection of bad debt? Is it appropriate for CMS to propose a rule that will likely result in further reimbursement cuts for SNFs?

Mr. Scully: As I just mentioned, CMS is reviewing the comments we have received on the proposed rule. Once the final policies for the final rule have been agreed to, we will be available to address the concerns you have raised about the impact of the rule on SNFs.

MEDICAID PHARMACY SERVICES

Mr. Regula: Last year the Subcommittee heard testimony on the issue of uncollected co-payments for pharmacy services under Medicaid. Under current policy, pharmacies are obligated to provide medications and attendant professional services to Medicaid beneficiaries, even if they cannot or refuse to pay this co-payment. Federal regulation prohibits States from compensating pharmacies for these uncollected co-payments, which we understand results in \$100 million in annual lost revenue for community pharmacies. This leaves pharmacies with little or no ability to recover this lost revenue, and as a result they are often dispensing prescriptions at an economic loss. Has CMS examined this situation and is it considering new policies that would ameliorate the current effects of uncollected co-payments on community pharmacies?

Mr. Scully: CMS is aware that retail pharmacies are concerned about the statute that prohibits denial of service when a Medicaid beneficiary is unable to pay a co-payment. We are also aware of the regulation which restricts Medicaid agencies from paying pharmacies and other providers for uncollected co-payments. We are examining this policy as part of our comprehensive review of Medicaid cost sharing policy.

HIPAA

Mr. Regula: Last year Congress extended the deadline for the administrative simplification requirement under HIPAA for an additional year. This was done to allow providers and payers more time to make the necessary system changes. Unfortunately, there are reports that many in the health care community are still not ready for this requirement. What is your understanding of the ability of providers to convert to the new standards this coming October and what is CMS doing to educate providers on what they need to do to be ready? Are you concerned that if providers aren't ready, they may revert to paper claims to avoid the HIPAA requirements?

Mr. Scully: As you indicated, the Administrative Simplification Compliance Act (ASCA) provided a 1-year extension of the deadline for compliance with HIPAA electronic transactions and code sets for covered entities that submitted a compliance plan before October 15, 2002. We believe that progress has been made during this extension period. However, like you, we are hearing concerns that the provider community still may not be ready by the October 16, 2003, compliance date, although there are some small studies that indicate that there will be a high level of compliance. CMS has conducted, and continues to conduct, a significant outreach campaign to ensure that providers, health plans, vendors, and associations are aware of the approaching deadline and are working towards timely compliance. For example, CMS hosts free HIPAA roundtable conference calls and offers a toll-free HIPAA Hotline to provide general HIPAA information and respond to questions. We also maintain a HIPAA website that contains a wealth of information on HIPAA administrative simplification, including answers to frequently asked questions, covered entity decision tools, and information about upcoming events such as roundtables, conferences, and satellite broadcasts. In addition, our regional offices conduct targeted HIPAA outreach activities within their respective regions, such as conference calls, informational seminars, and local newspaper and radio ads.

With regard to the concern of providers reverting to paper claims to avoid the HIPAA requirements, we are proactively advising providers of the negative effects of doing so. Providers' business processes would be disrupted by having to prepare paper claims and check eligibility and claim status by phone. Reverting to paper would cause particular problems for those providers who receive Medicare payments. First, these providers would experience delays in receiving payments because Medicare, by law, cannot pay paper claims until 28 days after receipt. Second, effective October 16, 2003, Medicare is prohibited by law from paying paper claims, except for those from small providers and under certain other limited circumstances. For these reasons, we are advising providers against reverting to paper claims.

FTE REDUCTION

Mr. Regula: Your budget proposes a reduction of 175 FTE from current levels. With your anticipated workload increases from Medicare reforms such as prescription drug benefits, is this a reasonable time to be cutting staff?

Mr. Scully: Although our FY 2004 budget request reflects an overall reduction of 175 FTE, we are not simply cutting staff. We are undertaking efforts to restructure the overall level and distribution of the Federal workforce within CMS. Our efforts involve determining the Agency's core competencies and then deciding whether to fill identified skill gaps through internal capacity, or through outsourcing to the private sector. Steps taken to streamline our organizational structure include reducing the overall number of managers and consolidating various administrative functions within the Agency. Affected personnel will be reassigned into front-line, mission-critical positions where they will have a more direct effect on customer service. By streamlining our organizational structure and eliminating redundant functions, we will reduce the overall number of FTEs required to perform our mission in an effective manner. Concurrent with efforts to streamline our workforce, we are aggressively implementing the President's Competitive Sourcing Initiative. We have identified 315 positions in FY 2003 and 210 positions in FY 2004 that will undergo competitive sourcing studies to determine the cost-effectiveness of outsourcing these functions to the private sector. When taken together with ongoing investments in productivity-enhancing technologies, we believe our FY 2004 staffing estimate, along with its associated payroll cost, is reasonable to meet the challenges facing CMS.

HIGLAS

Mr. Regula: What is the total cost of the HIGLAS accounting system and when do you expect it to be operational?

Mr. Scully: CMS estimates the total cost of HIGLAS at \$384.4 million. This figure is from our final business case analysis at the time of the contract award in September 2001. The FY 2004 President's Budget requests two-year spending authority for \$57 million of that total. CMS intends to substantially implement HIGLAS in the Medicare contractor community during FY 2005 and FY 2006 and to utilize HIGLAS as the official accounting record by the end of FY 2007.

QUALIFIED HIGH-RISK INSURANCE POOLS

Mr. Regula: The Trade Act of 2002 provided \$40 million for you to support qualified high-risk insurance pools. How are States making use of this funding?

Mr. Scully: The Trade Act of 2002 provides for \$40 million in grant funding for the operation of existing qualified high-risk insurance pools in both FY 2003 and FY 2004, for a total of \$80 million. States receiving this funding will utilize the money to cover up to 50 percent of losses incurred in their qualified high-risk insurance pools.

We hope that that some States, as result of receiving the funding, will expand eligibility of their qualified high-risk pools, thereby assisting more uninsured individuals. A regulation formally announcing the operation grant funding is slated to be put on display soon. This regulation includes a 60-day comment period. CMS chose to announce the funding through the regulation process in order to both clarify and allow feedback regarding the formula used to allocate the funding. Eligible States will have until September 30, 2003 to submit an application for losses incurred in their fiscal year 2002; June 30, 2004 for losses incurred in their fiscal year 2003; and June 30, 2005 for losses incurred in their fiscal year 2004.

HEALTHY START, GROW SMART

Mr. Regula: We were pleased to support the Healthy Start, Grow Smart program in the omnibus bill and to see it included in the FY 2004 request. Once this program gets underway, have you built in an evaluation component to judge which messages resonate the best with Medicaid parents and whether they have had an impact on behavior?

Mr. Scully: The Healthy Start, Grow Smart series of 13 pamphlets is an educational effort providing month-by-month information helpful to all parents, starting with the newborn, through each month of the child's first year. Each pamphlet contains specific information that cannot be evaluated against the others in the series. New parents receive child care and child development information in many forms and from numerous sources, including the hospital at the time of delivery and their healthcare providers; the goal is for these pamphlets to provide one more source of helpful information.

MEDICARE & YOU

Mr. Regula: What outside assessments have been made to judge whether the annual mailing of the *Medicare & You* brochure at a cost of nearly \$30 million is the most effective and efficient means to communicate with beneficiaries about the program.

Mr. Scully: The National *Medicare & You* Education Program (NMEP) Community Monitoring Survey indicates that two-thirds of beneficiaries are satisfied with the handbook. Survey data indicate that 66 percent of beneficiaries are satisfied, 17 percent are neither satisfied nor dissatisfied; 4 percent are dissatisfied or very dissatisfied; and the remaining 13 percent do not know or did not answer this question. In addition, research shows direct mailings are the most effective approach for communicating reference material to beneficiaries. All of the NMEP testing and assessment activities have consistently shown that most beneficiaries use the handbook as a reference document. We have revised the *Medicare & You* handbook to reflect its use as a reference document. Further, CMS continually explores ways to lower the cost of producing and distributing the handbook.

TOLL-FREE TELEPHONE INFORMATION

Mr. Regula: Have you found the 24-hour toll-free lines provide needed coverage to beneficiaries, or are you considering less manpower intensive alternatives?

Mr. Scully: CMS does not foresee altering our expanded services at 1-800-MEDICARE. Call volumes have increased since CMS expanded services to offer 24 hours a day, seven days a week access to customer service representatives (CSRs) at 1-800-MEDICARE. The call volume for the first quarter of calendar year 2003 was 4 percent higher than the same period for 2002. Call volume for 2002 was 11 percent higher than for 2001. CMS's 1-800-MEDICARE contractor continuously monitors call volume and adjusts staffing levels to ensure adequate numbers of CSRs are available to assist callers with their Medicare questions. CMS continues to examine ways to enhance services for beneficiaries. Customer satisfaction ratings for 1-800-MEDICARE consistently remain in the 88-92 percent range. Beneficiaries are benefiting from 24/7 access to CSRs at 1-800-MEDICARE and are pleased to have a CSR available at all times to answer their questions. During the overnight hours, all calls are forwarded to one call center as a means of keeping this service cost efficient.

MEDICARE APPEALS REFORM

Mr. Regula: You propose a modest effort (\$3 million) to begin work on the appeals for local and national coverage determinations. When that system is up and running, what do you expect the full-year costs to be? What share of appeals do you expect to cover in FY 2004?

Mr. Scully: CMS estimates that the full-year cost of handling appeals for local and national coverage determinations, as mandated by BIPA Section 522, will be \$20 million. Since the start-up phase could take up to 12 months, and require all of the requested \$3 million, case processing would probably begin in October 2004.

NURSING HOME QUALITY INITIATIVE

Mr. Regula: How many nursing homes are covered by the data released in the National Nursing Home Quality Initiative?

Mr. Scully: As of February 2003, we have released quality measure information on 16,702 nursing homes. This represents nearly all Medicare or Medicaid certified nursing homes.

Mr. Regula: Have the ratings been accepted by the providers or are you getting complaints that the factors used are unfair?

Mr. Scully: Providers, as a whole, view these measures as fair. Prior to using them for the national rollout in November 2002, many things were done to be sure they represented the result of the best available science of quality measurement. CMS

worked closely with The National Quality Forum — an independent body of experts — to decide which measures to use. Prior to the national rollout, a preliminary national validation on these measures was completed and results were reviewed by CMS. This study was conducted in six States with 209 nursing homes. CMS used the findings and expert opinion to make the final measure selection. Prior to the national rollout, every provider was given the opportunity to preview its own measures and discuss scores with CMS.

HOME HEALTH CARE AGENCIES

Mr. Regula: How long will it take for you to establish a similar system for home health care agencies?

Mr. Scully: On May 1, our www.medicare.gov website, “Home Health Compare” will go live with information on 11 different quality measures for every Medicare-certified home health agency in eight phase I States (Florida, Massachusetts, Missouri, New Mexico, Oregon, South Carolina, Wisconsin, West Virginia). Depending on the results from phase 1, we intend to roll this out for every home health agency nationally this fall.

Mr. Regula: Does the data come from Medicare files that already exist or have you had to collect new information?

Mr. Scully: The data already exist and are based on Outcome and Assessment Information Set (OASIS) data submitted by all Medicare certified home health agencies to their State.

DISEASE MANAGEMENT

Mr. Regula: Recently we have been made aware of disease management (DM) entities that work with chronically ill individuals to educate them on proper use of their medications, behavioral changes, and other lifestyle issues that can help to prevent hospitalizations. Some States have even begun to integrate DM programs into their Medicaid programs, and we understand that CMS is examining whether these programs should be part of the fee-for-service program. Can you tell me where you are in evaluating these programs and whether you see them becoming a part of the Medicare program?

Mr. Scully: CMS is actively exploring how to best incorporate disease management services into the fabric of its operations, specifically addressing the issues raised in the Institute of Medicine’s “Crossing the Quality Chasm” report. As such, CMS is undertaking a series of disease management demonstration projects that provide beneficiaries with greater choices, enhanced quality of care, especially for those who live with chronic illnesses, and offers better value for the dollars spent on healthcare. CMS will be assessing whether coordinated care and disease management programs can

improve medical treatment plans, reduce avoidable hospital admissions and promote other desirable outcomes, such as reducing health care disparities, without increasing program costs.

Two of these projects, the 3-year Medicare Case Management Demonstration and the 4-year Medicare Coordinated Care Demonstration are the two programs that have already begun enrolling beneficiaries. The Case Management Demonstration is designed to test whether intensive case management services for congestive heart failure and diabetes mellitus are a cost-effective means of improving the clinical outcomes, quality of life, and satisfaction with services for high-risk patients in the Medicare fee-for-service program. The Coordinated Care Demonstration is designed to test whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among Medicare beneficiaries with chronic diseases. An evaluation of both these demonstrations is underway. The first biannual Report to Congress on these programs will describe the initial findings and will be submitted in late spring 2004. The 16 sites participating in these two demonstrations provide a wide range of approaches affording CMS the opportunity to identify, on an ongoing basis, those programs or aspects of programs that are most effective and should be made a permanent part of the regular Medicare program.

Several other demonstrations are under development:

- The Benefits Improvement and Protection Act (BIPA) Disease Management Demonstration is designed to determine the impact on costs and health outcomes of offering disease management services and prescription drug coverage to Medicare beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary heart disease. CMS is currently reviewing the demonstration applications.
- The Capitated Disease Management Demonstration is designed to test whether risk bearing entities can administer and tailor health plans for Medicare beneficiaries with chronic diseases such as stroke, congestive heart failure, and diabetes; dual eligibles; and frail elderly using fully risk adjusted payments. A solicitation for demonstration sites was recently published and responses are due by the end of May 2003, with awards expected later this year.

MEDICARE CLAIMS

Mr. Regula: Identify the number of Part A and B claims projected to be paid in FY 2003 and FY 2004, along with the most current projections of cost per claim.

Mr. Scully: Below is a table with this information on claims:

	FY 2003 Current Estimate	FY 2004 President's Budget
Claims Volumes: (in millions)		
Part A	173.0	179.2
Part B	870.0	917.9
Total	1,043.0	1,097.1
Unit Costs: (in dollars)		
Part A	\$0.89	\$0.87
Part B	\$0.67	\$0.65

PRESIDENT'S MANAGEMENT AGENDA

Mr. Regula: Identify the components of the \$6 million savings assumed in the President's FY 2004 budget attributable to the President's Management Agenda.

Mr. Scully: The \$6 million savings will be accomplished by implementing CMS's FY 2004 Strategic Management of Human Capital Action Plan. The action plan will use a four-pronged approach based on administrative consolidation, layering, accountability, and strategic workforce planning. The savings will be realized through attrition based on task consolidation that results in the elimination of positions or FTEs.

SURVEY AND CERTIFICATION

Mr. Regula: Provide the ratings for each State survey agency with the revised State performance standards in the Survey and Certification program.

Mr. Scully: FY 2001 was the first year for State performance standards as part of the Nursing Home Oversight Improvement Program. However, as part of this effort we did not have a composite 'rating' for States. Rather, we reported to States whether they met, did not meet, or partially met the six performance standards. Six State agencies, including Missouri (which has two divisions), Montana, South Dakota, Pennsylvania, Utah, and West Virginia, met five of the six standards and partially met the remaining standard. Five State agencies failed to meet two standards, the greatest number of standards not met by a State. Those agencies included New Jersey, New York, Oklahoma, Texas, and Missouri.

We are currently in the process of analyzing results of the FY 2002 State performance standards.

STATE SURVEY & CERTIFICATION AND RESEARCH FTEs

Mr. Regula: How many Federal FTEs are associated with the survey and certification and research and evaluation functions within CMS?

Mr. Scully: There are approximately 508 FTEs currently performing both survey and certification workloads and research and evaluation workloads within CMS. Nearly 437 FTEs are performing nationwide survey and certification activities on behalf of our Medicare and Medicaid beneficiaries. Within CMS's Office of Research, Development, and Information, there are approximately 71 core FTEs engaged in both intramural and extramural research, demonstration and evaluation activities. This number does not reflect personnel within our other program offices, whose work may be included under a broad definition of the term research. For example, we have excluded personnel who are involved in the development of payment systems and quality assurance measures, as well as those who manage certain Medicare demonstration projects from the FTE total shown above.

SURVEY AND CERTIFICATION

Mr. Regula: How many facilities are removed from Medicare or Medicaid each year as a result of survey and certification reviews?

Mr. Scully: Below are the number of involuntary terminations from Medicare and Medicaid:

Involuntary Terminations By Provider Type								
Facility Type	1996	1997	1998	1999	2000	2001	2002	TOTAL
Hospitals	2	6	3	3	4	2	3	23
Nursing Homes	45	33	51	45	41	19	12	246
Home Health Agencies	59	63	75	57	41	20	14	329
Portable X-Ray	0	0	2	1	0	0	0	3
Outpatient Physical Therapy	2	6	3	2	3	5	2	23
End Stage Renal Disease	2	2	1	0	1	0	1	7
Intermediate Care Facilities for the Mentally Retarded	12	17	15	16	14	10	7	91
Rural Health Clinics	4	8	3	1	2	0	0	18
Outpatient Rehabilitation	0	0	0	2	0	1	1	4
Ambulatory Service Centers	3	4	4	4	0	2	1	18
Hospice	0	1	7	5	5	2	2	22
Organ Procurement	1	0	0	0	0	0	0	1
Community Mental Health Centers	1	3	4	12	2	2	0	24
Federally Qualified Health Centers	1	1	1	0	1	0	0	4
Clinical Labs	9	4	7	13	17	7	8	65
TOTAL	141	148	176	161	131	70	51	878

MEDICARE REFORM

Mr. Regula: What do you estimate as the Federal administrative costs for the Administration's Medicare reform proposals? Will the costs accrue to CMS or some other entity?

Mr. Scully: The administration's Medicare reform proposal would allow beneficiaries to select among three options: maintain benefits under the traditional Medicare program; select "enhanced Medicare," in which private health plans would provide coverage and other benefits; or enroll in "Medicare Advantage," which would be similar to the current Medicare+Choice program. The president's proposal also includes a subsidy for low-income beneficiaries that could be used to pay copayments or pharmaceuticals. The reform proposal is expected to cost \$400 billion over the next

10 years. At this time we do not have an administrative estimate for implementing the Medicare reform proposal. If legislation is passed in 2003, benefit changes will be phased-in. Beginning next year seniors will have the following benefits: All seniors will receive access to discounted drugs (discount of 10-25 percent) through Medicare-endorsed prescription drug discount cards; all low-income seniors will have access to drug discounts through the card, and additional assistance in purchasing prescription drugs. The remaining elements of the proposal would be implemented in 2006.

INFORMATION TECHNOLOGY FTEs

Mr. Regula: What reductions and FTE shifts does your FY 2004 budget assume for IT initiatives and outsourcing?

Mr. Scully: As indicated in our FY 2004 President's budget, we currently have a comprehensive IT workforce planning initiative in place to ensure that necessary skill sets are developed in support of our IT Modernization Initiative. CMS already outsources a substantial amount of our commercial IT activities, including infrastructure operations, programming support, and software development and maintenance. While IT Modernization may achieve both administrative and program savings over the next 5-10 years, we do not expect to achieve net FTE reductions in the short-term. The challenges of effectively planning and implementing the Modernization Initiative require that we redeploy any FTE replaced through attrition or outsourcing to support our Modernization Initiative.

SURVEY AND CERTIFICATION

Mr. Regula: Identify the number of facilities in each of the categories shown on page II-43 of the FY 2004 Congressional budget justification.

Mr. Scully: The projected numbers of Medicare participating facilities in FY 2004 are reflected in the chart below:

	TYPE OF FACILITY	NUMBER
1	Long-Term Care Facilities	15,172
2	Home Health Agencies	7,144
3	Accredited Hospitals	4,540
4	Non-Accredited Hospitals	1,747
5	ESRD Facilities	4,720
6	Hospices	2,387
7	Outpatient Physical Therapy	3,183
8	Outpatient Rehabilitation	615
9	Portable X-Rays	683
10	Rural Health Clinics	3,413
11	Ambulatory Surgical Centers	4,135

MEDICARE APPEALS REFORM

Mr. Istook: Based on our analysis of your agency's resources and needs for the coming year — and especially your priority to implement both the appeal reforms required by BIPA 521 and 522 and the transfer of the Medicare hearings workload to CMS — the \$129 million in your budget appears inadequate. There does not appear to be enough funding over the amount being transferred from the Social Security Administration to both set up the administration of the program and adequately address the requirements of the reforms in the law.

Please discuss for the Committee the planned transition process, the additional resources that will be required for the full implementation of BIPA, and the current backlogged cases by State.

Mr. Scully: CMS has developed separate transition processes for each of the major BIPA provisions:

- For section 521, CMS has proposed a legislative amendment in the FY 2004 budget that would provide an extension of the implementation deadline until 16 months after receipt of funding. This would allow sufficient time to proceed with rulemaking, award contracts to the qualified independent contractors (QIC), and develop necessary systems and operational support. If funds are received on October 1, 2003, these provisions could be fully implemented by February 2005. The budget request reflects this mid-year implementation.
- For section 522, implementation of coverage appeals is partly dependent on publication of the final regulation, which is currently in the clearance process, and on funding. CMS has requested \$3 million in FY 2004 for start-up activities. We plan to fully implement these provisions in FY 2005 and estimate that this will cost \$20 million annually.
- For Medicare hearings, the Department and the Social Security Administration (SSA) have agreed in principle to transfer this function currently performed by SSA's Office of Hearings and Appeals. Negotiations over the details of the transfer are on-going. CMS is preparing a Memorandum of Agreement that will reflect these decisions.

In FY 2004, we have requested initial implementation funding for section 521 and 522 provisions. Although we do not currently have a final estimate for the full implementation costs, we agree they will be higher than the \$129 million requested for FY 2004.

CMS would also incur significant costs once the Medicare hearings workload is fully transitioned. CMS is still determining the most effective manner to effectuate this transfer; however, our FY 2004 budget request provides the resources needed to build the framework of systems and operational support that needs to be in place to facilitate the transfer of the Medicare hearings workload.

Currently, the volume of backlogged Medicare hearings is about 39,000 cases. We do not have this data by individual State.

Mr. Istook: Please describe what you would be able to accomplish with an additional \$50 million in funding over the Administration's request?

Mr. Scully: In FY 2004, CMS would use additional funding to implement BIPA section 522 coverage appeals. CMS would also explore the possibility of a more expeditious implementation of section 521 changes.

Mr. Istook: Would this increase make it more likely that you could successfully complete these tasks?

Mr. Scully: CMS's request for \$3 million for the section 522 coverage appeals would cover only initial implementation activities. Additional funding would allow us to more fully implement these new coverage appeals next year.

MEDICARE HEARINGS TRANSFER

Mrs. Northup: I read in your statement and in a recent *New York Times* article that CMS will soon move the Medicare hearing function from the Social Security Administration (SSA) to house it within your agency. The *Times* article was particularly scathing in its assessment of alternatives to the current administrative law judge (ALJ) system, while failing to note both the current lag time of 300 days and the moratorium on ALJ hires that has been imposed on CMS for a number of years.

And while I agree that the Medicare hearing and appeals process would be better served in CMS, transferring the operation from SSA by October 1st seems to be a colossal, if not impossible, task. Do you believe that CMS possesses sufficient time and resources to accomplish this transition by the deadline?

Mr. Scully: The President's Budget proposes a transfer of the appeals process by FY 2004. The Department and SSA have agreed in principle to transfer this function currently performed by SSA's Office of Hearings and Appeals. Negotiations over the details of the transfer are on-going. CMS is preparing a Memorandum of Agreement that will reflect these decisions.

We can transfer the responsibility by October 1, 2003, and have requested new authority to use administrative mechanisms other than ALJs to help make this transition successful. The Federal Circuit Court recently lifted the moratorium on hiring ALJs, but until all appeal rights are exercised and the Court issues a mandate, OPM cannot re-open its ALJ hiring channels. Therefore, we still need the other administrative mechanisms. CMS's FY 2004 request provides the resources needed to build the framework of systems and operational support that needs to be in place to facilitate this transfer. The goal of the Administration's budget proposal is to design a process that provides fair and timely hearings for our Medicare beneficiaries.

BENEFITS OF MEDICARE HEARINGS TRANSFER

Mrs. Northup: Would moving the Medicare hearing and appeals process to CMS better serve our seniors? Please explain.

Mr. Scully: I believe that moving the Medicare hearing process to CMS would result in significant improvements in consistency, efficiency, and timeliness. We plan to establish a Medicare-specific ALJ or hearings officer corps for conducting Medicare hearings. These individuals would receive extensive training on Medicare programs and extensive expertise in adjudicating Medicare appeals to ensure that cases would be heard and resolved in a timely manner.

COST OF MEDICARE HEARINGS TRANSFER

Mrs. Northup: What costs will this additional workload impose on CMS? Do you anticipate any cost savings associated with in-house operations as opposed to the current arrangement with SSA?

Mr. Scully: The FY 2004 budget request includes \$129 million for the first year of implementing a reformed appeals process, including BIPA section 521 reforms and the transfer of the hearings function. We anticipate that, through training and specialization in Medicare issues, a Medicare-specific ALJ or hearings officer corps should be efficient and effective. Additionally, CMS plans to explore the wider use of video-teleconferencing. This would still allow for face-to-face hearings but would eliminate the need for expensive, and time-consuming, travel by both appellants and ALJs.

MORATORIUM ON HIRING NEW ALJs

Mrs. Northup: Why can CMS not hire ALJs? What alternatives do you envision for filling the needed ALJ duties within the Medicare appeals system?

Mr. Scully: The current moratorium on hiring new administrative law judges (ALJ) dates back to April 1999 when the Merit System Protection Board (MSPB) ruled in favor of the appellant in a lawsuit (*Azdell v. Office of Personnel Management (OPM)*) which claimed that OPM's 1996 scoring formula for ALJ examinations was unlawful. In February 2003, the Court of Appeals for the Federal Circuit overturned the MSPB's ruling in favor of OPM. However, until all possible petitions are filed and ruled on, the moratorium continues.

OPM has informally advised CMS that they expect this case to be settled in its favor but a final mandate, which would end the moratorium, may not be issued for several months. As a result, CMS has had to consider other possible options for adjudicating Medicare hearings, such as hiring administrative judges or permitting non-ALJs to make favorable, but not adverse, recommendations to ALJs. If this case is resolved in OPM's favor, CMS will be able to hire ALJs and not have to use alternatives. However, our budget request reflects the use of these alternative mechanisms.

IMPROVE MEDICARE HEARINGS PROCESS

Mrs. Northup: What can Congress do to ease this transition and provide for a new, more efficient and streamlined appeals process for Medicare beneficiaries?

Mr. Scully: We believe our FY 2004 budget request, which provides the resources and strategy for building the systems and operational support framework for this transfer, best represents an efficient and effective proposal for reforming the Medicare appeals process.

The level of funding in our budget request assumes that the proposed changes and the provision regarding increased flexibility in conducting Medicare hearings are both enacted. Without these changes, CMS's FY 2004 request is not adequate to implement BIPA section 521 reforms and effectuate the transfer of the hearings function.

NURSING HOME ADMINISTRATION

Mrs. Northup: As you know, nursing facilities are required to meet Federal regulatory standards in order to participate in Medicare/Medicaid programs. Compliance is determined by a State survey of the facility. But if, when the State survey agency conducts another visit to determine if the deficiencies enumerated in the first visit have been met, new deficiencies are found, CMS policy directs that State agency to ignore periods of compliance. This prevents facility recertification and perpetuates any enforcement action already in place, even when previous deficiencies have been corrected. The policy harms patients and facilitates because it can lead to premature termination from Medicare/Medicaid programs, termination for minor deficiencies and/or unwarranted continuation of enforcement actions such as civil monetary penalties.

Facilities which surveyors find to have substandard quality of care need to be closely monitored and appropriate remedies should be levied upon the facility. But basic fairness, as well as insuring that improvements can be made quickly, requires that the facility receive some leniency when they are subject to an extended survey.

What can you do to ensure that nursing home surveys are administered in a timely and non-adversarial process that works to the mutual benefit of both administrators and residents?

Mr. Scully: Our expectation is that nursing homes remain in compliance with Federal requirements at all times. However, our survey and certification program envisions that most nursing homes would have an opportunity to correct deficiencies unless there is a deficiency of such severity (such as an immediate jeopardy) or ongoing noncompliance as represented by a pattern of actual harm on two successive surveys.

In the situation you describe above, a facility was found out of compliance, corrected those deficiencies, and then as a result of the survey to verify compliance -- was found again to be out of compliance. When a nursing home is surveyed, surveyors look at the nursing home as a snapshot in time. The fact that new deficiencies were found at the revisit to the nursing home demonstrates the nursing home's inability to maintain compliance. Moreover, those deficiencies were more than likely to have been present before the revisit occurred. Even in those situations where new deficiencies were found at a revisit, the vast majority of nursing homes would get an opportunity to correct those deficiencies before a sanction would be imposed.

The number of remedies (sanctions) imposed over the last several years is relatively small. In FY 2002 less than a quarter of all nursing homes had sanctions of any kind. Of those nursing homes sanctioned, 28 percent had a denial of payment for new admissions and 53 percent had a civil money penalty imposed (ranging from \$50 to \$10,000). The remaining sanctions were State monitoring, directed plans of correction and directed in-service training.

CMS believes that sharing best practices with nursing homes as well as keeping open communication during its surveys helps make the survey process less adversarial. We are also committed to making surveys timely by enforcing our statutorily mandated survey intervals of a State-wide average of 12 months but no more than 15 months between surveys.

SURVEY AND CERTIFICATION

Mrs. Northup: Should facilities with the greatest problems be subject to more frequent surveys and higher performing facilities to less intensive scrutiny?

Mr. Scully: We agree that nursing homes with good compliance history should be surveyed less frequently than those with more problems. The Omnibus Budget Reconciliation Act of 1987 (OBRA '87), the statutory basis for nursing home reform, did envision such flexibility. The law permits States to survey some nursing homes within 15 months as long as the State-wide average is no more than 12 months. This permits States the flexibility to survey more problematic nursing homes more frequently. There is no minimum number of months between surveys stipulated by law.

Mrs. Northup: Would it be feasible to operate a system that surveys long-term care facilities at varying intervals based on performance?

Mr. Scully: It would be feasible to operate a system that surveys long-term care facilities at varying intervals based on performance as long as those surveys are conducted within the 15-month time period stipulated by statute.

To some extent, we already have such a process. Nursing homes with recurring problems (poor performance) are more likely to have complaints alleging noncompliance. In these cases, the State would be in the facility more frequently than a facility with no complaints.

Mrs. Northup: Would such a system allow for more focused intervention on the facilities most in need of adjustment?

Mr. Scully: We agree that a system where the most problematic nursing homes get more attention would be helpful. However, it is equally important to have a presence with all nursing homes. Again, we believe that States already have the flexibility to put more attention on nursing homes with compliance problems.

PEDIATRIC DENTISTRY

Mrs. Northup: I understand that CMS is reviewing an updated *Guide to Children's Dental Care under Medicaid*. Given that this document is intended to replace the existing document that is over 20 years old and no longer reflective of contemporary pediatric dental care, can you tell us when the final document will be released and can you ensure there is appropriate input from the Chief Dental Officer at CMS?

Mr. Scully: The *Guide to Children's Dental Care In Medicaid* is currently in the final stages of review. Dr. Allen Davis, our Chief Dental Officer has been actively involved in the process of updating this document.

DISEASE MANAGEMENT

Mrs. Northup: As you know, a very substantial proportion of Medicare and Medicaid costs are attributable to a small subset of the beneficiary population with multiple chronic conditions such as asthma, diabetes, congestive heart failure, and coronary artery disease. Anything we can do to prevent the onset of such conditions will pay dividends in the long run.

For those individuals who already suffer from chronic illness, it is often the case that expensive hospital re-admissions for this population can be avoided through management of their condition that provides education on such matters as the use of prescription drugs and self-monitoring; behavior modification reinforcement in areas such as diet, exercise, and smoking; and regularized communication and feedback. In light of this, there is growing interest in the role that disease management (DM) organizations can play in providing these types of services toward the goal of reducing health care costs and improving patient quality of life.

I understand that many States have now initiated DM programs under Medicaid, that most Medicare+Choice programs have active DM programs, and that CMS is examining the application of DM to fee-for-service Medicare.

Can you tell me what is being done at the Federal level to facilitate the use of DM in Medicaid and Medicare — especially fee-for-service Medicare?

Mr. Scully: CMS is actively exploring how to best incorporate disease management services into the fabric of its operations, specifically addressing the issues raised in the Institute of Medicine's "Crossing the Quality Chasm" report. As such, CMS is undertaking a series of disease management demonstration projects that provide beneficiaries with greater choices, enhanced quality of care, especially for those who live with chronic illnesses, and offers better value for the dollars spent on healthcare. CMS will be assessing whether coordinated care and disease management programs can improve medical treatment plans, reduce avoidable hospital admissions and promote other desirable outcomes, such as reducing health care disparities, without increasing program costs.

Two of these projects, the 3-year Medicare Case Management Demonstration and the 4-year Medicare Coordinated Care Demonstration are the two programs that have already begun enrolling beneficiaries. The Case Management demonstration is designed to test whether intensive case management services for congestive heart failure and diabetes mellitus are a cost-effective means of improving the clinical outcomes, quality of life, and satisfaction with services for high-risk patients in the Medicare fee-for-service program. The Coordinated Care Demonstration is designed to test whether coordinated care programs can improve medical treatment plans, reduce

avoidable hospital admissions, and promote other desirable outcomes among Medicare beneficiaries with chronic diseases. An evaluation of both these demonstrations is underway. The first biannual Report to Congress on these programs will describe the initial findings and will be submitted in late spring 2004. The 16 sites participating in these two demonstrations provide a wide range of approaches affording CMS the opportunity to identify, on an ongoing basis, those programs or aspects of programs that are most effective and should be made a permanent part of the regular Medicare program.

Several other demonstrations are under development:

- The Benefits Improvement and Protection Act (BIPA) Disease Management Demonstration is designed to determine the impact on costs and health outcomes of offering disease management services and prescription drug coverage to Medicare beneficiaries with advanced-stage congestive heart failure, diabetes, or coronary heart disease. CMS is currently reviewing the demonstration applications.
- The Capitated Disease Management Demonstration is designed to test whether risk bearing entities can administer and tailor health plans for Medicare beneficiaries with chronic diseases such as stroke, congestive heart failure, and diabetes; dual eligibles; and frail elderly using fully risk adjusted payments. A solicitation for demonstration sites was recently published and responses are due by the end of May 2003, with awards expected later this year.

Mrs. Northup: I understand that a major challenge is posed in providing DM services to the so-called "dual eligible" population — generally comprised of individuals who qualify for Medicaid as a consequence of their income but also qualify for Medicare as a consequence of age or, often, disability. In this high cost population, State Medicaid programs have only a very limited incentive to manage the care of these individuals because the vast bulk of any realized savings would accrue to Medicare and not Medicaid.

Has CMS given any thought to how we can better promote the provision of DM services to this population?

Mr. Scully: We are encouraging dual-eligible beneficiaries to participate in all of our coordinated care/disease management demonstrations. Because the demonstrations will focus on those beneficiaries with the most serious chronic conditions and those with the most intense medical needs, we expect a significant proportion of the demonstration enrollees to be dual eligibles. In addition, as noted previously, the forthcoming Capitated Disease Management Demonstration will specifically target dual-eligible beneficiaries as one of the populations that CMS is interested in including.

Mrs. Northup: Do you intend to suggest changes in the delivery system?

Mr. Scully: With both the current and planned disease management demonstrations, we will be testing a wide variety of programs from basic case management to "high-tech" monitoring of beneficiaries' conditions. The evaluation results from this wide range of approaches will enable us to identify those programs or aspects of programs that improve the quality of care while stabilizing or reducing Medicare costs. Based on this evaluation, we will consider the merits of integrating disease management into the Medicare program.

Mrs. Northup: To provide appropriate DM services to the Medicare population requires a fairly sophisticated "triaging" of patient data. Beneficiaries who can benefit from such services need to be identified and directed toward these services.

Can you tell me what the current capabilities are with the Medicare program to identify candidates for DM services, and what types of changes or enhancements to existing data management and related systems would be needed to develop the IT architecture and systems infrastructure to facilitate this?

Mr. Scully: We are currently exploring ways of identifying beneficiaries who would benefit from disease management services. CMS is in the process of developing procedures to use the existing Medicare claims database to identify beneficiaries who, because of their health conditions, might benefit from participation in these programs. Thus, as part of our developmental work for forthcoming disease management demonstrations we expect to leverage existing IT assets for short-term basic demonstration requirements, but also identify needed enhancements to the IT architecture and to the systems infrastructure so that CMS is positioned to support these initiatives on a program-wide scale.

PRESCRIPTION DRUGS

Mr. Weldon: There is currently no incentive for a provider to take the time to review the multiple drugs that a patient may be taking to determine if there is a more cost-effective drug regimen for that person. I used to take the time with my patients, to review their drugs, to find out if perhaps there was a cheaper alternative to their prescriptions. This is very time consuming for a doctor and I believe that this is a disincentive for a provider to undertake such reviews. There is no billable code for a provider who takes the time to review and revise a senior's prescription drug regimen to help that senior eliminate unnecessary drugs and find cheaper alternatives. If such a code were to be established, there would have to be strong safeguards to ensure that this benefit was not abused by providers. As we consider how to address the issue of prescription drugs for seniors, this is going to be an increasing area of concern. It is prudent that we take steps to ensure that seniors are not over-medicated and that there is serious consideration given to the costs of drugs being prescribed.

Has CMS given any consideration to addressing this issue? If so, what were the conclusions? If not, do you plan on asking for a review of this matter and under what timeframe would you consider this?

Mr. Scully: Most recent legislative proposals and the President's Framework to Modernize and Improve Medicare plan to make heavy use of pharmacy benefit managers (PBMs) to administer a prescription drug benefit. PBMs can play a substantial role in helping beneficiaries choose the most cost-effective drugs, as well as protecting them from adverse events and dangerous drug combinations.

In their role as claims processors, PBMs naturally build up a complete database of the medications that patients are taking, and the companies employ sophisticated software to help pharmacists and physicians monitor patients' drug use. PBMs can alert patients when a cheaper generic equivalent is available, and their formularies often give patients an incentive to use the most cost-effective drug in its therapeutic class. PBMs often distribute pocket versions of these formularies to physicians and make them available on their websites for quick reference.

Even beyond cost control, however, PBMs can play a role in protecting patient safety through a process called drug utilization review (DUR). Using their databases, the PBMs can alert providers when a patient is taking a dangerous combination of medicines, or when medicine dosages need to be adjusted. The individual prescribing physicians may not know about these adverse drug interactions in cases where the patient sees multiple doctors. The exciting thing about this process is that the computer checks happen in real time — at the retail pharmacy counter and before the patient ever takes the dangerous drug combination. PBMs can also monitor the patients' compliance with drug regimens — when they are filling prescriptions more often or less often than prescribed — and communicate such information so that the prescribing physician can ask about it on the next visit.

DEFENSIVE MEDICINE

Mr. Weldon: Has CMS studied the costs of defensive medicine on the Medicare budget, comparing costs and outcomes in States with strong medical malpractice laws to States without malpractice caps? Could you provide the Committee with information comparing utilization and Medicare costs in States like California versus States like West Virginia, Washington, D.C., Pennsylvania, and Florida?

Mr. Scully: CMS has not conducted or funded any studies on this issue. The latest report on this issue was released by HHS on March 3, 2003, titled "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care." The report is available at www.aspe.hhs.gov/daltcp/reports/medliab.pdf. Based on a study by Kessler and McClellan that is referenced in the HHS report, it is estimated that "reasonable limits on non-economic damages can reduce health care costs from 5 through 9 percent without substantial effects on mortality or medical complications." California has had this type of limit in effect for 25 years. We will submit information on State utilization rates and Medicare costs under separate cover.

BENEFITS IMPROVEMENT AND PROTECTION ACT

Mr. Obey: What is the current status of implementation of the appeal rights and procedures required by sections 521 and 522 of the Benefits Improvement and Protection Act of 2000?

Mr. Scully: CMS has taken a series of steps to implement the substantial changes required by this law, as described below. Our goal has been to put CMS in the best possible position to implement BIPA 521 requirements once these issues are resolved. Major steps include:

- In September 2002, CMS issued a ruling regarding procedures for Medicare contractors, ALJs, and the Departmental Appeals Board to use for handling initial determinations and appeals as of October 1, 2002. This interim guidance addressed short-term implementation issues and implemented some BIPA 521 provisions, including establishing a new 120-day deadline for filing requests for redeterminations of claims denials and setting the threshold for the amount in controversy for ALJ hearings at \$100.
- Subsequently, CMS published a Request for Information (RFI) to solicit industry comments in connection with a BIPA 521 requirement that CMS contract with at least 12 Qualified Independent Contractors (QICs) to conduct reconsiderations, which would be the second level of appeals. We obtained comments on a draft statement of work for prospective bidders and other interested members of the industry. Using these comments, we have developed a Request for Proposal (RFP) to solicit bids for the QIC work. We intend to release the RFP once appeals funding issues are resolved.
- On November 15, 2002, we published a comprehensive proposed rule covering all necessary regulatory changes related to BIPA 521, as well as other long-needed changes aimed at volume control, fairness and efficiency, and the creation of Medicare-specific ALJ regulations. We are now considering the comments on the proposed rule and are in the process of developing the final rule for publication later this year.
- We have also developed specifications for the data system needed to implement the BIPA 521 changes and anticipate entering into a contract by late June 2003 to begin building this system.

To implement BIPA section 522, CMS has published a notice of proposed rulemaking (August 2002) and is preparing the final regulation for clearance and publication. Our FY 2004 request for \$3 million will cover start-up activities such as developing a database and a tracking system, and training the ALJs and Medicare contractors on the new processes. We anticipate that this phase will take up to 12 months and that case processing would begin October 2004. Once this workload is fully implemented, we estimate that it will cost \$20 million annually.

CMS has a process in place for interested parties seeking a change in a national coverage determination. It has also established a process for parties to use when seeking reconsideration of a local medical review policy.

IMPLEMENTATION OF BIPA SECTIONS 521 AND 522

Mr. Obey: If the appropriations requested for this purpose are provided, what do you anticipate will be the status of implementation of BIPA sections 521 and 522 in FY 2004? Can we expect these provisions of law to be fully implemented by the end of FY 2004? If not, what is your proposed timetable for implementation and when will implementation be complete? How would this answer change if legislation is enacted extending the implementation deadline until 16 months after funding is provided, as proposed by CMS?

Mr. Scully: Once the appropriations requested for BIPA section 521 are provided, CMS would initiate the contracting process for the new qualified independent contractors (QICs) required by section 521—a process requiring about 9 months. After contracts have been awarded, we estimate that each QIC will need 4 to 6 months to hire and train staff, develop protocols, implement a data system, etc. Thus, the entire process could take 15 months before the QICs can begin processing cases. If we receive an appropriation on October 1, 2003, we project that the earliest that case processing would begin is the first quarter of calendar year 2005. Therefore, our proposal extends the implementation deadline until 16 months after funding is provided.

Our FY 2004 request for section 522 included \$3 million for start-up activities. We anticipate being able to fully implement these provisions by the beginning of FY 2005. Our full-year estimate for section 522 is \$20 million.

MORATORIUM ON HIRING NEW ALJs

Mr. Obey: Your testimony indicates that an injunction against hiring new administrative law judges (ALJs) has complicated the task of shifting the Medicare hearing function from the Social Security Administration (SSA) to CMS. What is the current status of this injunction and the underlying litigation? If an injunction remains in place, does the Administration plan to ask the court to lift or modify the injunction in order to allow hiring of the ALJs needed by CMS (as I believe was done previously for SSA)?

Mr. Scully: CMS has requested new authority to use administrative mechanisms other than ALJs to help make this transition successful. The Federal Circuit Court recently lifted the moratorium on hiring ALJs, but until all appeal rights are exercised and the Court issues a mandate, OPM cannot re-open its ALJ hiring channels. Therefore, we still need the other administrative mechanisms.

ALTERNATIVE MECHANISMS FOR ALJ REVIEWS

Mr. Obey: The Administration's budget requests insertion of a proviso into the CMS program management appropriations language to allow the Secretary to "use alternative mechanisms in lieu of Administrative Law Judge review" for Medicare appeals. Let me ask several questions about this language request:

Precisely what "alternative mechanisms" would you use for handling Medicare appeals if this language were to be enacted? Would hearings be provided? What types of officers or employees would adjudicate appeals in lieu of ALJs? What law would govern the procedures and standards for decision-making?

Mr. Scully: Among the options we have considered as alternatives to administrative law judges (ALJ) have been hiring administrative judges or permitting non-ALJs to make recommendations to ALJs, particularly in cases they believe should be decided in favor of the appellant. The same laws that govern the current procedures and standards for decision-making would still apply. We have not considered using arbitration or mediation or Department lawyers, as has been reported in a recent newspaper article.

Mr. Obey: What safeguards would be employed to ensure the independence and impartiality of the officials handling Medicare appeals under these alternative mechanisms?

Mr. Scully: We recognize the need for these decision-makers to remain independent and impartial and would seek to apply the same safeguards that currently exist.

Mr. Obey: Why is the Administration seeking this appropriations proviso, rather than proposing legislation to amend the relevant provisions of permanent law?

Mr. Scully: We looked at this as something that was specifically tied to our FY 2004 appropriation request, rather than a permanent change in the law.

BENEFITS IMPROVEMENT AND PROTECTION ACT

Mr. Obey: Your budget justifications indicate that CMS is proposing several legislative changes to BIPA sections 521 (and perhaps to section 522 as well) including extension of the implementation deadline, reduction in the minimum number of qualified independent contractors, and extension of decision-making timeframes. Has proposed legislation to implement these recommendations been transmitted to Congress? If not, how and when will these proposals be transmitted?

Mr. Scully: We have not yet provided actual legislative language to Congress that would amend BIPA sections 521 and 522. Recently proposed legislation in the House (HR 810) contains a provision to reduce the number of qualified independent

contractors from 12 to "not fewer than 4," which was one of our proposals. The legislation does not extend the implementation deadline, or increase the decision-making timeframes under the BIPA appeals process.

SURVEY AND CERTIFICATION

Mr. Obey: The Administration's budget request for survey and certification of nursing homes and other health facilities appears to represent roughly a 2 percent decrease from the level appropriated two years earlier (FY 2002). What is the reason for this proposed reduction?

Mr. Scully: While it is true that the total FY 2004 President's budget request for the Medicare Survey and Certification program is lower than the FY 2002 appropriation, the portion of the budget dedicated to inspections of nursing homes and other Medicare providers by State survey agencies in FY 2004 reflects a \$6.8 million increase from the FY 2002 enacted level.

Additionally, the FY 2004 budget assumes about \$8 million in contracts supporting the Nursing Home Oversight Improvement Program will be funded through the budget for the Quality Improvement Organizations.

Mr. Obey: How are payments to State survey agencies determined under the Medicare Survey and Certification program? How have these payments changed over time and how are they expected to change in FY 2004 under your proposed budget?

Mr. Scully: Since FY 1998 the total amount of the national Medicare survey and certification budget provided to State survey agencies has steadily increased. CMS greatly appreciates the continued support by this Subcommittee and the Administration for this critical program.

Approximately 92 percent of the national Medicare survey and certification budget is allocated to State survey agencies to conduct federal inspections of nursing homes, home health agencies, hospitals, and other non-long-term-care facilities. Since FY 2001, CMS has generally determined its final State survey agency budget allocation levels based on an analysis of three key factors: original State agency budget requests; accompanying CMS Regional Office recommendations; and internal budget and data analyses to include analysis of combined national average survey times for skilled nursing facilities (SNFs) and SNF/Nursing Facilities (NFs). This analysis supports the CMS Government Performance and Results Act (GPRA) goal to promote more consistency in the effective and efficient utilization of survey and certification resources. We anticipate this budget allocation process to continue into FY 2004.

Mr. Obey: What have been the trends over the past several years in the number and seriousness of deficiencies found during nursing home surveys?

Mr. Scully: Below is a chart depicting the numbers and seriousness of nursing home deficiencies. Level "B" represents the least severe, while level "L" represents the highest scope and severity.

TABLE OF SCOPE BY YEAR							
SCOPE	YEAR						
*Severity Level	1997	1998	1999	2000	2001	2002	TOTAL
B	11,026	9,301	8,058	9,351	10,087	9,286	57,109
C	6,344	5,850	5,935	6,558	6,049	5,173	35,909
D	30,980	35,420	40,944	47,826	52,446	49,037	256,653
E	17,819	19,783	21,565	24,920	24,122	22,868	131,077
F	3,964	4,467	5,169	5,699	5,319	4,538	29,156
G	8,948	9,800	9,881	7,674	5,979	4,792	47,074
H	1,324	1,468	1,208	871	523	350	5,744
I	112	114	79	59	19	20	403
J	116	266	232	272	344	316	1,546
K	141	209	209	329	368	335	1,591
L	44	70	94	121	134	113	576
TOTAL	80,818	86,748	93,374	103,680	105,390	96,828	566,838

*B and C represent no actual harm with potential for minimum harm.

D, E, and F represent no actual harm with potential for more than minimum harm that is not immediate jeopardy.

G, H, and I represent actual harm that is not immediate jeopardy.

J, K, and L represent immediate jeopardy to resident health and safety.

CMS PERFORMANCE GOALS

Mr. Obey: One of the CMS performance goals for the Survey and Certification program is to decrease the prevalence of pressure ulcers among nursing home residents. The goal that has been set by CMS is for some modest reductions in prevalence — from 9.8 percent in FY 2000 to 9.6 percent in FY 2001 and 9.5 percent in FY 2002, with no further reductions in FY 2003 or FY 2004. However, your performance report indicates that the prevalence of pressure ulcers went up, rather than down, in FY 2001 and that interim data suggests the target for FY 2002 will be missed as well. What steps are you planning to take to remedy this situation and to meet or exceed your goal of reducing pressure ulcers among nursing home residents?

Mr. Scully: CMS has evaluated the data relative to the increase in prevalence of pressure ulcers in nursing homes. We believe that this increase in prevalence may stem in large part from an increase in case-mix (severity of illness) of the nursing home population and from other constraints that nursing facilities are facing. We are working to better understand and address these variables. However, given these factors, CMS is committed to continuing efforts to increase awareness of, and improve the identification of, a resident's risk for the development of avoidable pressure ulcers. In order to achieve this, we are providing an increase in training for both surveyors and nursing home providers in the area of prevention and/or treatment of pressure ulcers in nursing home residents. We have recently had an opportunity to meet with some of our stakeholders, such as the State Agency Directors, and reaffirmed our GPRA goal as well as our efforts in attempting to decrease the prevalence of pressure ulcers in nursing homes. We have convened a panel of nationally recognized clinicians in the area of pressure ulcers, and have developed improved guidance to surveyors in the area of pressure ulcers. In addition, a satellite presentation on the clinical issues regarding the identification of risks for the development of pressure ulcers is being planned. This effort will include mandatory attendance for all surveyors, and will be accessible for nursing home providers. We intend to maintain our presence and oversight in evaluating the care provided to nursing home residents, especially in relation to the development of pressure ulcers. We are maintaining our target of 9.5 percent, as we reevaluate our future methodology for this performance goal.

Mr. Obey: A second CMS performance goal for the Survey and Certification program is to decrease the use of restraints in nursing homes. However, after achieving a decrease in FY 2000, the CMS performance goal seems to be to just hold the prevalence of restraint use constant at the FY 2000 level of 10 percent through FY 2004. Why don't your goals seek to achieve further reductions? What is CMS doing to help bring about a further reduction in use of restraints?

Mr. Scully: When GPRA began, our baseline rate for physical restraints was 17.2 percent for FY 1996. We set our target goal at 14 percent for FY 1999 and met that goal by having a physical restraint use rate of 11.9 percent. For the past 3 years we have kept our target rate at 10 percent. In FY 2000 the rate was 10 percent, for FY 2001 the rate was 10 percent and interim data for 2002 shows the rate at 9.9 percent. While

we continue to work with nursing homes on ways to reduce the use of physical restraints, CMS is committed to maintaining this measure of nursing home quality care and therefore will carefully assess trends and explore alternate measurement approaches for this goal.

Use of restraints is one of the quality measures on which we are now reporting publicly (on medicare.gov) as part of the Nursing Home Quality Initiative, which we launched nationally in November 2002. We anticipate that as a result of this initiative, facilities will develop heightened awareness of their performance in this area, and will undertake activities to improve performance. Medicare's Quality Improvement Organizations (QIOs) have been contracted to provide improvement assistance to facilities in each State, and about 15 percent of facilities are now working fairly intensively with QIOs to improve on one or more of the publicly reported measures. Before we determine future goals in the area of restraints, we want to assess the impact of this initiative on current trends, and therefore, will maintain the current target at 10 percent.

DRUG COVERAGE

Mrs. Lowey: As you know, patients react differently to different medications, which is why patients must have access to the treatment that is therapeutically best for them. Despite this, CMS issued a program memorandum directing Medicare carriers to cover only one of the four FDA-approved injectable multiple sclerosis (MS) drugs. This ill-conceived decision increases the risk that patients will either take the wrong therapy, or that they will not be able to afford to take any of the therapies — thereby increasing the rate of exacerbations and disability and adding additional Medicare Part B costs. Can you please explain why Part B coverage of multiple sclerosis therapies is limited? Is it because of the way CMS is interpreting the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA)? If yes, since the Administration's interpretation of current law is to limit coverage to only one of the four available drugs, what does CMS think needs to be done, such as Congressional action, in order to remedy this untenable limitation on coverage? If it is not because of BIPA, how do you explain the Administration's policy to limit the clinical choices available to multiple sclerosis patients and their physicians?

Mr. Scully: President Bush believes our nation has a moral obligation to fulfill Medicare's promise of health care security for America's seniors and people with disabilities. To meet this obligation, the nation must act now to bring Medicare into the 21st century. The President, the Secretary, and I are urging Congress to provide more choices and better benefits, including prescription drugs, to all Medicare beneficiaries including those suffering from multiple sclerosis. I look forward to working with you to achieve this important goal.

It is also the goal of CMS to ensure that all Medicare beneficiaries have access to appropriate high quality care in accordance with the current Medicare statute. On May 15, 2002, CMS issued instructions to our contractors with guidance on how to implement section 112 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) regarding drugs usually self-administered by the patient. On October 11, 2002, CMS issued additional guidance regarding implementation of the new BIPA standard. These instructions and guidance include criteria to be used by Medicare contractors in determining whether a drug is usually self-administered by the patient and, therefore, excluded from coverage under Medicare. Under the criteria outlined in the instructions, some MS drugs will be covered by Medicare, while others may not be covered. Contractors will make this determination following the process outlined in the instructions. Once a contractor makes its determinations regarding drugs usually self-administered, it will post its list of excluded drugs on its website.

Under the criteria, a drug is "usually" self-administered if more than 50 percent of the Medicare beneficiaries who use the drug administer it to themselves. Thus, if a drug is self-administered by more than 50 percent of Medicare beneficiaries,

it does not meet the BIPA standard for coverage under Medicare. The instructions provide our contractors with presumptions to assist them in determining if a drug is usually self-administered. There are two primary presumptions:

- Drugs administered intravenously or intramuscularly are presumed to be not usually self-administered. The MS drug Avonex is administered intramuscularly.
- Drugs administered subcutaneously are presumed to be usually self-administered. The MS drugs Betaseron, Rebif, and Copaxone are provided in premixed formulations and are administered subcutaneously.

However, these presumptions may be overcome with evidence to the contrary.

CMS issued the criteria to implement a statutory change made by Congress. Congress can expand coverage for those MS drugs that are not covered today by passing the President's Medicare reform proposal which includes a drug benefit for all beneficiaries.

MEDICAID

Mrs. Lowey: As you know, State Medicaid programs serve as an important safety net for Americans in need by ensuring access to critical health and long-term care services. Currently the Medicaid program provides coverage to 47 million Americans. Twenty million, or one in four U.S. children, are covered by this program, as well as 8.6 million adults, 4.1 million elderly, and 7 million blind and disabled individuals. Unfortunately, reduced State revenues are placing severe strains on many State budgets and could limit Medicaid at a time when additional coverage and spending is most needed. How do you think Congress and CMS should respond to this crisis? Would you support efforts to increase Federal Medicaid payments (FMAP) to the States?

Mr. Scully: Because of the Federal participation in Medicaid, States have a strong fiscal incentive to expand coverage under Medicaid as much as possible. Yet, 38 states have made program reductions in the past year: 13 cut eligibility; 19 cut services; 8 increased cost sharing; and 23 reduced provider payments. One hundred twenty-five thousand (125,000) beneficiaries already have lost coverage and most States are considering new or additional eligibility criteria or benefit reductions. The reason for this is that under the current financing methodology, in order to draw down Federal matching funds to expand eligibility, States must be able to increase State Medicaid expenditures as well. The simple reality is that States do not have the State funds needed to take advantage of the Federal match to expand coverage. Despite the loss of Federal funds that will result, tight fiscal constraints are forcing States to cut their programs and reduce coverage.

The Administration's Medicaid modernization proposal will enable States to avoid the cutbacks being made today, and even to expand eligibility, within current budget limits. The Administration's proposal provides for this ability by giving States an infusion of additional Federal funds in the first 7 years and by providing States with considerable flexibility to streamline and restructure their programs. This, in turn, will enable States to spend their Medicaid dollars more effectively.

The greater flexibility afforded to States in designing their benefit packages alone will help States to avoid eliminating, and even to expand, coverage. Because they would be able to tailor benefit packages to meet the needs of different populations, States would not be forced to eliminate an optional service for all beneficiaries or an entire optional eligibility group in order to save costs. Conversely, States would be more likely to expand coverage to optional populations, even in tight fiscal times, because they could offer a more modest benefit package that is more in line with coverage in the private insurance market, rather than having to offer new populations all services covered under the State plan.

The response to the August 2001 HIFA initiative undeniably demonstrates States' interest in expanding coverage to the uninsured if given the flexibility to make appropriate programmatic reforms, even in these tight fiscal times. Moreover, the ability of States to streamline and simplify their programs under the modernization proposal will also generate savings. Under the current funding mechanism, a reduction in State expenditures would result in a corresponding reduction in Federal matching funds. Under the modernization proposal, however, the State's Federal allotment would not be reduced provided the State maintains a level of effort. Thus, any savings generated by the State under the reform could be used to expand coverage.

**DEPARTMENT OF
HEALTH
AND HUMAN
SERVICES**



**FISCAL YEAR
2004**

**CENTERS FOR MEDICARE &
MEDICAID SERVICES**

*Justification of
Estimates for
Appropriations Committees*



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED
LEADERSHIP

As of
January 14, 2003
* Acting

ADMINISTRATOR

Thomas A. Scully

DEPUTY ADMINISTRATOR

and Chief Operating Officer

Leslie Norwalk *

Vacant, Senior Advisor for Policy

Leslie Norwalk, Counselor to the Administrator

OFFICE OF OPERATIONS
MANAGEMENT

Jared Adair, Director

Brenda Sykes, Associate Director

OFFICE OF EQUAL
OPPORTUNITY AND
CIVIL RIGHTS

Ramon Soto-Fernandez, Director

Patricia Lamond, Dep. Dir.

CENTER FOR
BENEFICIARY CHOICES

Carol Martin, Director

Michael McQuinn, Dep. Dir.

Vacant, Deputy Director

for Beneficiary Education
for Health Plans

CENTER FOR MEDICARE
MANAGEMENT

Tom Grissom, Director

Elizabeth Casick, Dep. Dir.

CENTER FOR MEDICAID
AND STATE OPERATIONS

Dennis G. Smith, Director

Chantene Brown, Dep. Dir.

OFFICE OF CLINICAL
STANDARDS AND QUALITY

Robert A. Steiner, Dir. *

Sean Tullis, M.D., Dep. Dir. *

& Chief Clinical Officer

OFFICE OF RESEARCH,
DEVELOPMENT
& INFORMATION

Shant Goleman, Director

William Saunders, Deputy Dir. *

OFFICE OF
THE ACTUARY

Rick Foster

Chief Actuary

OFFICE OF INTERNAL
CUSTOMER SUPPORT

Vacant, Director

Ellen Gochhauser, Dep. Dir.

OFFICE OF INFORMATION
SERVICES

Tim Love, Dir.

Wallace Fung, Dep. Dir.

(Technology)

OFFICE OF FINANCIAL
MANAGEMENT

Michelle Snyder, Director

& Chief Financial Officer

Lee Mossdale, Dep. Dir.

OFFICE OF STRATEGIC
OPERATIONS AND
REGULATORY AFFAIRS

Jacquelyn White, Director

Debra McKelvin, Dep. Dir.

OFFICE OF LEGISLATION

Robert D. Foreman, Director

Donald Johnson, Dep. Dir.

PUBLIC AFFAIRS OFFICE

Dallas (Rob) Swezey, Director

Peet Ashkenz, Dep. Dir.

BOSTON REGIONAL OFFICE

Vacant, Reg. Admin.

Lynna Silva, Dep.

NEW YORK REGIONAL OFFICE

Gilbert Kunken, Reg. Admin. *

Gilbert Kunken, Dep.

PHILADELPHIA REGIONAL OFFICE

Sonia Madison, Reg. Admin. ^{1/}

Nancy O'Connor, Dep.

ATLANTA REGIONAL OFFICE

Rose Crum-Johnson, Reg. Admin. ^{2/}

Patricia Harris, Dep.

DALLAS REGIONAL OFFICE

James Rudolph Ferris, M.D., Reg. Admin.

Roger Perez, Dep.

CHICAGO REGIONAL OFFICE

Vacant, Reg. Admin.

David Durie, Dep.

KANSAS CITY REGIONAL OFFICE

Joe Tighnam, Reg. Admin. ^{3/}

Richard Brummet, Dep.

DENVER REGIONAL OFFICE

Alex Trujillo, Reg. Admin.

Spencer Erisson, Dep.

SAN FRANCISCO REGIONAL OFFICE

Vacant, Reg. Admin.

H. Stephen Dearing, Dep.

SEATTLE REGIONAL OFFICE

Linda A. Ruiz, Reg. Admin. ^{4/}

John Hammerfield, Dep.

^{1/} The RA serves as Northeastern Consortium Administrator for the Boston, New York, and Philadelphia Regional Offices

^{2/} The RA serves as Southern Consortium Administrator for the Atlanta and Dallas Regional Offices

^{3/} The RA serves as Midwestern Consortium Administrator for the Chicago and Kansas City Regional Offices

^{4/} The RA serves as Western Consortium Administrator for the Denver, San Francisco and Seattle Regional Offices

Volume Contents

BUDGET SUMMARY

Funding Summary.....	I-1
Discretionary Budget Summary.....	I-2
Executive Summary.....	I-3

PROGRAM MANAGEMENT

Appropriation Language	II-1
Language Analysis, Current Law	II-3
Appropriation Summary Table, Current Law	II-5
Appropriation Summary Table, Proposed Law	II-6
Proposed Legislation Summary	II-7
Medicare Operations	II-9
Federal Administration	II-29
Medicare Survey and Certification	II-39
Research, Demonstration and Evaluation	II-49
CMS Revitalization Plan	II-55

OTHER APPROPRIATED ACCOUNTS

Medicaid Grants to States	III-1
Payments to the Health Care Trust Funds.....	III-23
HMO Loan and Loan Guarantee Fund	III-33

PRESIDENT'S MANAGEMENT AGENDA

President's Management Agenda Summary	IV-1
---	------

SUPPORTING INFORMATION

Program Management

Table V-1 Amounts Available for Obligation	V-1
Table V-2 Summary of Changes.....	V-2
Table V-3 Budget Authority by Activity	V-3
Table V-4 Budget Authority by Object - 2 Year.....	V-4
Table V-5 Salaries and Expenses.....	V-6
Table V-6 Appropriations History Table.....	V-7
Table V-7 Authorizing Legislation.....	V-8
Table V-8 Detail of Full-Time Equivalent Employment.....	V-9

Volume Contents, Continued

Program Management (Contd.)

Table V-9 Detail of Positions	V-10
Table V-10 Voluntary and Involuntary Terminations	V-11
Table V-11 Change in Configuration	V-12

Grants to States for Medicaid

Table V-12 Summary of Changes.....	V-13
Table V-13 Authorizing Legislation.....	V-14
Table V-14 Appropriations History Table.....	V-15
Table V-15 Medicaid Requirements.....	V-16
Table V-16 Budget Authority by Object.....	V-17
Table V-17 Amounts Available for Obligation	V-18
Table V-18 Adjusted State Estimates	V-19
Table V-19 Estimates of Grant Awards.....	V-20
Table V-20 Proposed Law	V-22
Table V-21 Vaccines for Children Program	V-23

Other

Information Technology	V-24
Medicare Benefits	V-31
Clinical Laboratory Improvement Amendments of 1988	V-33
Audited Financial Statement.....	V-37
Health Care Fraud and Abuse Control.....	V-39
State Grants and Demonstrations.....	V-49
National <i>Medicare & You</i> Education Program	V-53
State Children's Health Insurance Program	V-59
Significant Items	V-65
Benefits Improvement and Protection Act.....	V-73

ANNUAL PERFORMANCE PLAN AND REPORT

Executive Summary.....	VI-1
Part I - Overview of Performance Measurement	VI-4
Part II - Goal-By-Goal Performance Measurement	VI-7
Part III - Appendices	VI-182

Section I Contents

BUDGET SUMMARY

Funding Summary.....I-1

Discretionary Budget Summary.....I-2

Executive Summary.....I-3

Funding Summary

FY 2004 Total Obligations (Current Law)	\$463,868,635,000
Federal Benefits: 1/	\$449,493,463,000
Medicare	\$278,632,000,000
Medicaid 2/	\$167,686,263,000
State Children's Health Insurance Program	\$3,175,200,000
Federal Operating Costs:	\$14,375,172,000
State Agents:	\$9,452,695,000
Medicaid Agencies	\$9,067,320,000
Survey and Certification Agencies	\$247,647,000
Clinical Laboratory Surveyors	\$43,000,000
State Grants and Demonstrations	\$94,728,000
Private Sector Agents:	\$3,086,889,000
Intermediaries and Carriers 3/	\$1,834,889,000
Health Care Fraud and Abuse Control	\$1,075,000,000
Peer Review Organizations	\$99,600,000
Medicare+Choice User Fee	\$14,000,000
Research Contractors and Grantees	\$63,400,000
Federal Agencies:	\$1,835,588,000
Social Security Administration	\$1,182,000,000
Centers for Medicare & Medicaid Services 3/, 4/	\$589,618,000
Other (Treasury, OIG, etc.)	\$63,970,000
CMS Full-Time Equivalent (FTE) Staff 5/	4,408

1/ Corresponding benefit outlays total \$451.4 billion.

2/ The Medicaid benefits shown above include funds for the Vaccines for Children program.

3/ Includes funding for CMS's proposed revitalization plan.

4/ Includes \$580.6 million in the Federal Administration portion of CMS's Program Management appropriation, plus user fees from the sale of data.

5/ Does not include 78 FTEs which are funded solely from user fees.

**Discretionary Budget Summary
Non-Comparable**

CMS Program Management	2002 Actual 1/	2003 President's Budget 2/	2004 Estimate	Increase or Decrease
Medicare Operations	\$1,534,500,000	\$1,675,084,000	\$1,776,889,000	\$101,805,000
Enacted Rescission (P.L. 107-116)	-500,000	—	—	—
Enacted Rescission (P.L. 107-206)	-2,000,000	—	—	—
Subtotal, Medicare Operations 3/	1,532,000,000	1,675,084,000	1,776,889,000	101,805,000
Federal Administration	531,700,000	562,497,000	580,571,000	18,074,000
Enacted Rescission (P.L. 107-116)	-215,000	—	—	—
Enacted Rescission (P.L. 107-206)	-1,000,000	—	—	—
Subtotal, Federal Administration	530,485,000	562,497,000	580,571,000	18,074,000
State Survey and Certification	256,397,000	247,647,000	247,647,000	—
Enacted Rescission (P.L. 107-116)	-2,000,000	—	—	—
Enacted Rescission (P.L. 107-206)	-1,312,000	—	—	—
Subtotal, State Survey and Certification	253,085,000	247,647,000	247,647,000	—
Research, Demonstration and Evaluation	118,201,000	28,400,000	63,400,000	35,000,000
Enacted Rescission (P.L. 107-116)	-1,000,000	—	—	—
Subtotal, Research	117,201,000	28,400,000	63,400,000	35,000,000
Revitalization Plan 4/	—	—	65,000,000	65,000,000
Subtotal, Appropriation/BA (C.L.) 5/	\$2,432,771,000	\$2,513,628,000	\$2,733,507,000	\$219,879,000
Offsetting Collections: Current Law				
HMO User Fee	—	153,000	—	-153,000
Sale of Data User Fee	2,260,000	2,013,000	2,047,000	34,000
Medicare-Choice User Fee	14,497,000	16,000,000	14,000,000	-2,000,000
CLIA User Fee	43,731,000	43,000,000	43,000,000	—
Reimbursables	5,287,000	—	—	—
Subtotal, Offsetting Collections (C.L.)	\$65,775,000	\$61,166,000	\$59,047,000	-\$2,119,000
Program Level, Current Law	\$2,498,546,000	\$2,574,794,000	\$2,792,554,000	\$217,760,000
Offsetting Collections: P.L. [non-addl] 6/				
Duplicate/Unprocessable Claims User Fee	—	[130,000,000]	[195,000,000]	[65,000,000]
Appeals Filing User Fee	—	—	[6,000,000]	[6,000,000]
Program Level, Proposed Law	\$2,498,546,000	\$2,574,794,000	\$2,792,554,000	\$217,760,000
CMS FTEs				
Direct (Federal Administration)	4,333	4,498	4,315	-183
Commissioned Corps (Federal Admin.)	84	83	83	—
Direct HIPAA (Medicare Operations)	—	—	10	10
Reimbursable (CLIA)	80	80	78	-2
Subtotal, Current Law FTEs	4,497	4,661	4,486	-175
Medicaid Oversight (HCFAC)	—	—	100	100
Total, Proposed Law FTEs	4,497	4,661	4,586	-75

1/ The FY 2002 actual column reflects final (net) appropriation after all rescissions, transfers and reprogrammings. The FY 2002 actual column also reflects actual year-end FTE consumption.

2/ This column reflects the current estimate for FY 2003. Appropriated funds in the FY 2003 President's budget were \$2,538,330,000. The FY 2003 FTE count also reflects our current estimate. Our estimate in the President's budget totaled 4,476 FTEs.

3/ The fiscal year 2004 Medicare Operations request includes \$122.0 million for the National *Medicare & You* Education Program. This estimate includes \$12.5 million for the SHIP grants.

4/ Our FY 2004 request includes \$65.0 million in revitalization plan funding to undertake a fundamental modernization of our existing systems infrastructure. This effort will ensure that CMS and its contractors have the ongoing capability to meet the requirements of the Medicare program and to provide quality service to our beneficiaries.

5/ In addition, in fiscal year 2003, CMS has available to obligate the remaining \$33.5 million in no-year funding for standard systems transitions and managed care redesign activities.

6/ Our FY 2004 proposed law request includes \$201.0 million in funding for two user fees. We request \$195.0 million for the continuation of duplicate and unprocessable claims user fees and \$6.0 million for filing appeals with the independent review entities mandated by BIPA section 521.

BUDGET SUMMARY

Executive Summary**INTRODUCTION**

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency responsible for overseeing Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). The CMS also oversees the Medigap insurance industry and enforces the Clinical Laboratory Improvement Amendments (CLIA) and health insurance reform. It is also responsible for implementing hundreds of provisions in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Balanced Budget Act (BBA) of 1997, the Balanced Budget Refinement Act (BBRA) of 1999, the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWILA), the Benefits Improvement and Protection Act (BIPA) of 2000, and the Trade Act of 2002.

Size and Scope of CMS Responsibilities

- ◆ CMS is the largest purchaser of health care in the world.
- ◆ Medicare and Medicaid pay approximately one-third of national health expenditures.
- ◆ CMS programs provide health care coverage to approximately 82 million beneficiaries, or one in four Americans.
- ◆ CMS is second only to Social Security in the level of Federal spending.
- ◆ Medicare contractors process over 1 billion fee-for-service claims, answer 45 million inquiries, process nearly 8 million appeals, enroll and educate providers, and assist beneficiaries.
- ◆ CMS finances and oversees more than 71,000 inspections and complaint investigations of health care facilities each year and oversees 15,000 nursing homes.
- ◆ CMS distributes about 38 million *Medicare & You* handbooks to beneficiaries and stakeholders and answers between 9 and 10 million calls to the 1-800-MEDICARE toll-free telephone line.
- ◆ Medicaid is the largest long-term care insurer of Americans.
- ◆ CMS has worked to review and approve an SCHIP plan for every State, territory, and commonwealth. SCHIP covers 4.8 million children nationwide.

BUDGET SUMMARY

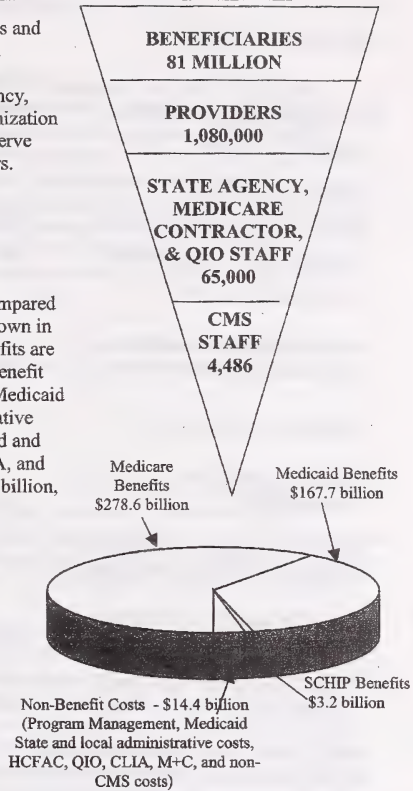
- ◆ CMS oversees approximately 10,900 inspections and complaint investigations of clinical laboratories.

CMS staff leverages the efforts of 65,000 State agency, Medicare contractor and quality improvement organization (QIO), formerly peer review organization, staff to serve 82 million beneficiaries and over 1 million providers.

Efficiently-Run Programs

CMS is committed to administering its programs as efficiently as possible. Non-benefit costs, most of which are administrative costs, are minute when compared to Medicare, Medicaid, and SCHIP benefits. As shown in the pie chart, Medicare, Medicaid, and SCHIP benefits are expected to total \$449.5 billion in FY 2004. Non-benefit costs, which include CMS Program Management, Medicaid State and local administration, non-CMS administrative costs, and costs associated with the health care fraud and abuse control account (HCFAC) and the QIO, CLIA, and Medicare+Choice programs, are estimated at \$14.4 billion, or 3.2 percent of total benefits. FY 2004 Program Management costs are less than 1.0 percent of benefits, and Medicaid State and local administrative costs are 5.2 percent of benefits.

The following pages of this summary describe, in detail, the Program Management piece of this pie.



FRAMEWORK FOR FY 2004 BUDGET REQUEST

CMS's budget needs are driven largely by the amount of work we must complete, such as processing over 1 billion claims, answering 45 million inquiries, processing nearly 8 million appeals, and conducting over 71,000 health care facility inspections and complaint investigations. In formulating our FY 2004 request, we focused primarily on the President's Management Agenda items, as well as on priority areas specific to HHS and CMS such as educating consumers and implementing enacted legislation which would improve the appeals process and simplify administrative procedures.

BUDGET SUMMARY

FY 2004 OVERVIEW

<u>Activity (dollars in millions)</u>	<u>FY 2002 Actual</u>	<u>FY 2003 Pres. Budget</u>	<u>FY 2004 Request</u>	<u>Percent Change</u>
Medicare Operations ^{1/}	\$1,605.0	\$1,748.1	\$1,776.9	+1.6%
Federal Administration	\$530.5	\$562.5	\$580.6	+3.2%
Medicare Survey & Certification	\$253.1	\$247.6	\$247.6	--
Research, Demo. & Evaluation	\$117.2	\$28.4	\$63.4	+123.2%
CMS Revitalization Plan	--	--	\$65.0	--
Total, Program Management Appropriation, Current Law	\$2,505.8	\$2,586.6	\$2,733.5	+5.7%
Proposed Law User Fees	--	(\$130.0)	(\$201.0)	--
Total, Proposed Law Appropriation	\$2,505.8	\$2,456.6	\$2,532.5	+3.1%
Offsetting Collections, Current Law	\$65.8	\$61.2	\$59.0	-3.5%
Offsetting Collections, Proposed Law	--	\$130.0	\$201.0	+54.6%
Total, Proposed Law Program Level	\$2,571.6	\$2,647.8	\$2,792.6	+5.5%

1/ The FY 2002 and FY 2003 columns include a \$73 million comparability adjustment for the costs of processing Medicare appeals under the Benefits Improvement and Protection Act (BIPA) of 2000.

For FY 2004, CMS requests a proposed law discretionary program level of \$2,792.6 million. This includes a Program Management appropriation request of \$2,733.5 million offset by \$201.0 million of proposed law user fees. This would result in a total proposed law appropriation of \$2,532.5 million, a 3.1 percent increase over the comparable FY 2003 President's budget.

We have submitted a legislative proposal that modifies the current BIPA statute and submitted appropriations language that provides additional flexibility in processing the Medicare appeals workload currently performed by the Social Security Administration. Assuming enactment of these proposals, CMS believes it can achieve efficiencies in the appeals processes that will enable us to handle the workloads with the requested level of funds.

BUDGET SUMMARY

Offsetting Collections, Proposed Law

- ◆ **User Fees:** As discussed in the Program Management section of this budget request, CMS proposes two user fees in FY 2004: a continuation of the fee proposed in the FY 2003 President's budget for submitting duplicate and unprocessable claims, and a new fee for providers who file appeals with the independent review entities mandated by BIPA section 521. This request assumes that the duplicate/unprocessable claims fee will be approved in FY 2003; FY 2004 estimated collections of \$195 million reflect a full year of collections and an increase in the fee, from \$1.50 to \$2.50. CMS expects to collect \$6 million in FY 2004 from the appeals user fee. Enactment of these fees is offsetting, and will reduce CMS's program management request by \$201 million.

Note: CMS is no longer proposing a user fee for paper claims since HIPAA administrative simplification requires electronic claims submission effective FY 2004.

Medicare Operations

The Medicare Operations account provides funding for a variety of activities, including the on-going work performed by the Medicare contractors; operational support, primarily information technology costs; activities that implement recent legislation; and improvements that enhance the Medicare program. The FY 2004 request for Medicare Operations is \$1,776.9 million, an increase of \$28.8 million or 1.6 percent over the comparable FY 2003 President's budget.

Some of the major items for FY 2004 include: an increase of \$47.6 million to keep up with a rapidly-growing claims workload; \$122.0 million, the same level as FY 2003, to continue our National *Medicare & You* Education Program; \$126 million (of a total of \$129 million for BIPA) to begin implementing appeals reform provisions of BIPA section 521 and to transfer the Medicare hearings workload from the Social Security Administration; \$35.1 million for HIPAA provisions; and \$5 million in start-up costs for the new Medicare-endorsed prescription drug card.

CMS continues to emphasize projects that bolster the Secretary's efforts to modernize and strengthen the Department's systems environment, such as the Unified Financial Management System (UFMS) and the Department's Information Technology Enterprise Infrastructure Fund. CMS requests a total of \$57 million (\$53.3 million in Medicare Operations and \$3.7 million in Federal Administration) for the Healthcare Integrated General Ledger Accounting System (HIGLAS), a part of the UFMS. We are again proposing 2-year spending authority for HIGLAS activities.

BUDGET SUMMARY

Federal Administration

The majority of the Federal Administration budget covers salaries and benefits of CMS's Federal employees with the remainder covering information technology, contracts, travel, training, and other costs. CMS's FY 2004 request is \$580.6 million, an increase of \$18.1 million or 3.2 percent over the FY 2003 President's budget. This request assumes a 2.0 percent pay increase in calendar year 2004. It supports 4,408 direct FTEs, including 10 new FTEs for the HIPAA enforcement activity (funded through the Medicare Operations account), and 78 indirect FTEs. In addition, CMS plans to hire additional staff for Medicaid oversight, to be funded through the HCFAC account.

In support of the Administration's "Healthy Start, Grow Smart" program, the request includes \$13 million for a series of booklets that will provide parents and families who are receiving Medicaid services with information on ways to assure the healthy development of newborns through their first year of life. The Federal Administration line item also includes \$3 million in start-up costs to implement the national and local coverage appeal provisions of BIPA section 522.

Survey and Certification

The Survey and Certification budget provides funding to the States for surveys, complaint visits, and associated costs. It also covers survey and certification support contracts managed internally in CMS. The FY 2004 request for Survey and Certification is \$247.6 million, the same as the FY 2003 President's budget. This request will fund initial surveys and complaint visits as well as the continuation of FY 2003 President's budget Nursing Home Oversight Improvement Program (NHOIP) activities. Other direct survey costs and support contracts are also included. This request will allow CMS to inspect long-term care facilities and home health agencies at the legislatively-mandated frequencies.

Research

The FY 2004 request for the Research, Demonstration, and Evaluation budget is \$63.4 million, an increase of \$35.0 million above the FY 2003 President's budget. This amount includes \$40 million for Real Choice Systems Change grants, \$3 million for the New Freedom initiative, and \$20.4 million to continue projects initiated in previous years. These include the Medicare Current Beneficiary Survey, beneficiary information campaign, refinement and monitoring of prospective payment systems, and support for Medicare modernization efforts, as well as for many provisions of the BBA, BBRA, and BIPA mandates.

BUDGET SUMMARY

Implementing BIPA Sections 521 and 522

- ◆ Section 521 significantly revises the Medicare appeals process. Key changes include a new reconsideration process conducted by qualified independent contractors (QIC), a uniform process for handling Part A and Part B appeals, a new right to an expedited appeal, much shorter time frames at all appeals levels, an “escalator” clause, and reduced amounts in controversy needed to file an appeal. CMS has proposed several changes to the existing BIPA legislation which it believes will improve the appeals process. These include an extension of the implementation deadline until 16 months after funding is provided, a reduction in the number of QICs from 12 to 4, and an increase in BIPA decision-making timeframes.

CMS requests \$126 million in FY 2004 to implement Medicare appeals reforms, including an amended version of BIPA section 521 and the transfer of the Medicare hearings function from the Social Security Administration (SSA). First-year costs will be lower than later years because it will take the QICs a few months to reach full processing capacity. Within this overall funding level, CMS will establish a new independent review process for Medicare appeals and work with SSA to transition the Medicare hearings currently heard by SSA’s administrative law judges (ALJ). CMS will also develop and implement a new case control system to track Medicare appeals. Of the total, \$6 million will be funded through a user fee proposal which would charge providers \$50 to file an appeal with the QIC. Due to the current moratorium on hiring new ALJs, CMS has requested the authority to use administrative mechanisms other than ALJs, such as hearings officers. CMS’s first-year costs assume that the proposed legislative changes discussed above are enacted. *The additional FTEs needed for this new workload are not reflected in the totals shown throughout this document.*

- ◆ Section 522 creates a new administrative appeals process for national coverage determinations (NCD) and local coverage determinations (LCD). There is currently no external review for either. This section also creates additional avenues for beneficiaries to seek judicial review. This request includes \$3 million for start-up activities related to BIPA section 522.

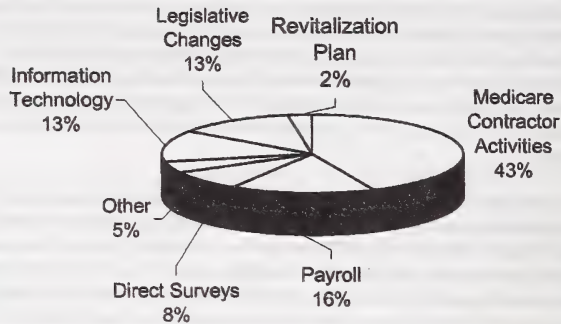
A more detailed description of BIPA activities is included in the Supporting Information section.

Breakout of Program Management Activities

The pie chart below breaks out the major activities within the Program Management account. Of our total Program Management budget, 67 percent is comprised of Medicare contractor activities, payroll, and direct surveys. The remaining 33 percent funds Administration priorities and fixed costs including facilities operations, single-site mortgage, and data center operations.

BUDGET SUMMARY

Breakout of FY 2004 Program Management Activities



Total Program Management Request = \$2,733.5 million (current law appropriation)

FY 2004 BUDGET PRIORITIES

Educating Consumers

During FY 2004, CMS will again focus on educating consumers, investing \$122.0 million in discretionary resources, the same level as FY 2003, toward the National *Medicare & You* Education Program (NMEP). The five main goals of this program are to ensure that beneficiaries:

- ♦ can access information when they need it, including culturally and linguistically appropriate formats;
- ♦ perceive *Medicare & You* as a trusted and credible source of information;
- ♦ receive accurate, reliable, and relevant information through the CMS information channels;
- ♦ understand their choices; and
- ♦ receive understandable information so that they can make the best choice based on price, quality, and convenience.

To support these objectives, CMS plans to continue its expanded and enhanced services provided through the NMEP. CMS will continue to reach beneficiaries with a national publicity campaign, ensuring that beneficiaries understand their health plan choices and

BUDGET SUMMARY

how to get more information to help them in their decision-making. Improvements and enhancements will be based on formative research, evaluation, and assessment results. Beneficiaries will continue to have access to customer service representatives, at 1-800-MEDICARE, 24 hours per day, 7 days per week. Also, the Medicare Personal Plan Finder, a customer-friendly interactive database, will continue to assist beneficiaries in understanding their health plan options. Additionally, CMS will continue its grant relationship with State Health Insurance Assistance Programs that provide telephone and face-to-face outreach and assistance at the State and local level.

Reducing the Burden on Our Partners and Focusing on Poor Performers

CMS wants to create a culture that is open, accessible, and responsive to our partners, making it easier for them to understand our programs and navigate our organization. To accomplish this, the Medicare Operations budget includes funding for provider education and training; for MedLearn, an effort to develop innovative activities to educate providers on Medicare coverage and billing information; and for the Physicians Regulatory Issues Team, an effort to respond to physicians' complaints about the Medicare regulatory process.

CMS's current program integrity focus continues our efforts to better differentiate between fraudulent providers and those making honest mistakes.

Strategic Management of Human Capital

CMS's FY 2004 budget supports the President's Management Agenda and includes cost savings from consolidating administrative functions, organizational layering to speed decision making processes, competitive sourcing, implementation of effective workforce planning and human capital management strategies, and adoption of other economies and efficiencies in administrative operations.

CMS is committed to making the best use of its current workforce, more accurately predicting immediate and long-term human capital needs, preparing for turnover in an aging workforce, and ultimately satisfying stakeholders that CMS is managing its human resources responsibly. Initiatives currently underway include:

- ◆ a comprehensive workforce planning initiative that includes retirement, retention, and demographic analyses; quantification of the human resources devoted to CMS business functions; and identification of the knowledge and skills required to achieve the agency's strategic goals. An automated system supporting this initiative is expected to be fully operational by the end of FY 2003;
- ◆ the establishment of a project planning and management staff to work directly with the Deputy Administrator on both program and administrative issues; and
- ◆ the CMS leadership and management development strategy (LMDS), designed to build proficiency in the disciplines of management and leadership by developing systems and practices that promote a high standard of leadership throughout the agency.

BUDGET SUMMARY

Improving Financial Performance

CMS supports the Unified Financial Management System (UFMS), which will integrate the Department's financial management structure, promote the consolidation of accounting operations throughout HHS, and reduce the cost of providing accounting services throughout HHS. CMS's FY 2004 request includes \$3.0 million in support of this effort.

This request also includes \$57.0 million, in 2-year spending authority, to continue efforts to implement the healthcare integrated general ledger accounting system (HIGLAS). HIGLAS, a part of the Department-wide UFMS, represents the consolidation of two major projects: the integrated general ledger and accounting system (IGLAS) project, which was initiated to improve the accounting and financial management processes used by Medicare contractors to administer the fee-for-service component of the Medicare program and the financial accounting and control system (FACS) redesign project, which involves replacement of CMS's current legacy accounting system and related systems, including travel management, grants management, asset management, and procurement.

When fully implemented, HIGLAS will:

- ◆ standardize the collection, recording, and reporting of financial information by Medicare contractors;
- ◆ provide an integrated, enterprise-wide system supporting administrative and program financial management needs; and
- ◆ ensure compliance with statutory financial management requirements, address concerns of the General Accounting Office and the Office of Inspector General (OIG), and enable CMS to retain a clean audit opinion.

The budget also supports efforts to reduce erroneous Medicare fee-for-service payments that do not comply with Medicare laws and regulations. An HHS OIG study of the period FY 1996-2002 found that the error rate decreased from 14 percent to just over 6 percent. Beginning in FY 2003, CMS will replace the OIG audit with the results of its comprehensive error rate testing (CERT) program. CMS also plans to use \$20 million from the HCFAC account to support Medicaid financial management, including hiring additional staff to improve the fiscal integrity of the Medicaid program and to strengthen Federal oversight of the States' financial practices.

Annual Performance Plan and Annual Performance Report

CMS's Annual Performance Plan (APP) complements and supports the Agency's FY 2004 budget request and is integral to it. CMS's FY 2004 and revised FY 2003 APP and the FY 2002 Annual Performance Report (APR) are attached at Tab VI.

CMS has taken care to ensure that major budget categories, including both program benefits and program administration funds, have adequate coverage in the APP. The CMS performance plan and report are organized by budget category to provide a

BUDGET SUMMARY

linkage of performance goals, program activities, and dollar amounts. These linkages ensure that in setting performance goals, CMS selects goals that are representative of the full range of Agency activities and resources.

Beginning in FY 2004, agency budgets will focus on results-oriented government guided by performance. The Office of Management and Budget developed the Program Assessment Rating Tool (PART) to evaluate programs in a systematic and objective manner, using numeric scores which rate overall program effectiveness and highlight strengths and weaknesses. In 2002, two of CMS's programs, the Medicare Integrity Program (MIP) and the State Children's Health Insurance Program (SCHIP), were assessed using the PART. Both programs received high scores. As a result of the PART process, CMS has included in its FY 2004 APP two new program integrity goals measuring the Medicare contractor error rate and provider compliance rate.

The overall number of goals has remained relatively stable. CMS has increased the proportion of outcome-oriented goals that speak to fundamental program purposes and to the agency's role as a steward of taxpayer dollars. CMS's total number of FY 2004 goals in the APP is 37, with reporting on 35 FY 2002 goals.

Multi-Year Revitalization Plan

The Medicare program has undergone extensive changes since 1965 when it was designed as an acute care, fee-for-service, health insurance program. Over the last 35 years, it has grown from 40 million claims and \$3.3 billion in benefit payments to an estimated one billion claims and \$279 billion in benefits in FY 2004. The health care industry has also changed drastically, with providers emphasizing preventive services and the use of pharmaceuticals, and insurance companies diversifying and moving into managed care. Congress has made dramatic changes to the program as well, adding some preventive benefits, enacting a managed care option, and changing benefit payment policies.

In spite of all these changes, the legislative framework of CMS's program administration has remained unchanged. CMS has struggled to make this work under demands not anticipated when Medicare was created. However, operations have become increasingly fragile.

Over the past few years, CMS has taken steps towards revitalizing its operations, such as reducing the number of standard fee-for-service claims processing systems. However, an overall revitalization cannot be accomplished without some fundamental infrastructure improvements. In particular, CMS's systems infrastructure was not designed to keep pace with recent changes in the program or to handle today's massive claims volume, much less the increase in claims volume that will come as today's "baby boomers" become eligible for Medicare. CMS has a window of opportunity over the next few years in which to make the changes needed to continue to meet the demands of the Medicare program and provide quality service to Medicare beneficiaries, but a significant investment is required.

BUDGET SUMMARY

To begin to meet this challenge, CMS is requesting a multi-year investment fund, with \$65 million in 2-year money to be appropriated in FY 2004. In the first year, the plan will focus on systems-related activities. A more detailed description of the proposed activities is included in the Program Management section of this document.

CONCLUSION

The CMS FY 2004 current law appropriation request represents a 5.7 percent increase over the comparable FY 2003 President's budget level. This budget will meet CMS's basic operational needs while supporting the goals of the Administration and the Secretary. It will allow CMS to continue beneficiary education efforts, improve financial management processes, improve relations with stakeholders, increase access to care, provide health care choices for beneficiaries, and increase efficiencies. CMS believes that we can continue to make meaningful changes to the programs we administer within these funding levels. The justifications in the following pages reinforce this commitment to our stakeholders and highlight our program administration plans for FY 2004.

Section II Contents

PROGRAM MANAGEMENT

Appropriation Language	II-1
Language Analysis, Current Law	II-3
Appropriation Summary Table, Current Law	II-5
Appropriation Summary Table, Proposed Law	II-6
Proposed Legislation Summary	II-7
Medicare Operations	II-9
Federal Administration	II-29
Medicare Survey and Certification	II-39
Research, Demonstration and Evaluation	II-49
CMS Revitalization Plan	II-55

PROGRAM MANAGEMENT

**Program Management
Appropriation Language**

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the Public Health Service Act, and the Clinical Laboratory Improvement Amendments of 1988, not to exceed \$2,733,507,000, to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the Public Health Service Act and section 1857(e)(2) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall remain available until expended, and together with administrative fees collected relative to Medicare overpayment recovery activities, which shall remain available until expended: Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the Public Health Service Act shall be credited to and available for carrying out the purposes of this appropriation: Provided further, That \$65,000,000, to remain available until September 30, 2005, is for contract costs for CMS's Systems Revitalization Plan: Provided further, That \$56,991,000, to remain available until September 30, 2005, is for contract costs for the Healthcare Integrated General Ledger Accounting System: Provided further, That not less than \$129,000,000 shall be for processing Medicare appeals: Provided further, That the

PROGRAM MANAGEMENT

Secretary may use alternative mechanisms in lieu of Administrative Law Judge review:

Provided further, That the Secretary of Health and Human Services is directed to collect fees in fiscal year 2004 from Medicare+Choice organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

Note.—A regular 2003 appropriation for this account had not been enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 107-229, as amended). The amounts included for 2003 in this budget reflect the Administration's 2003 policy proposals.

PROGRAM MANAGEMENT

Language Analysis

Language Provision	Explanation
<i>For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the Public Health Service Act, and the Clinical Laboratory Improvement Amendments of 1988, not to exceed \$2,733,507,000, to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 201(g) of the Social Security Act;</i>	Provides a one-year appropriation from the HI and SMI Trust funds for the administration of the Medicare, Medicaid, and State Children's Health Insurance programs. The HI Trust Fund will be reimbursed for the Federal Funds allocation of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
<i>together with all funds collected in accordance with section 353 of the Public Health Service Act and section 1857(e)(2) of the Social Security Act, and such sums as may be collected from authorized user fees and the sale of data, which shall remain available until expended,</i>	Provides total funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fees collected. Authorizes the collection of HMO user fees, fees for the sale of data, and other authorized user fees to cover administrative costs associated with processing HMO applications and providing data to the public. All of these collections are available to be carried over from year to year.
<i>and together with administrative fees collected relative to Medicare overpayment recovery activities, which shall remain available until expended:</i>	Authorizes the collection of fees if a provider requests a second audit of an overpayment amount determination. These collections are available to be carried over from year to year.
<i>Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the Public Health Service Act shall be credited to and available for carrying out the purposes of this appropriation:</i>	Authorizes the crediting of HMO user fee collections to the Program Management account.

PROGRAM MANAGEMENT

Language Analysis

Language Provision	Explanation
<i>Provider further, That \$65,000,000, to remain available until September 30, 2005, is for contract costs for CMS's Systems Revitalization Plan:</i>	Authorizes \$65,000,000 of this appropriation to be available for obligation over a period of two fiscal years, for contract costs pertaining to CMS's investment in systems infrastructure.
<i>Provided further, That \$56,991,000, to remain available until September 30, 2005, is for contract costs for the Healthcare Integrated General Ledger Accounting System:</i>	Authorizes \$56,991,000 of this appropriation to be available for obligation over a period of two fiscal years, for contract costs pertaining to the development and implementation of the Healthcare Integrated General Ledger Accounting System.
<i>Provided further, That not less than \$129,000,000 shall be for processing Medicare appeals: Provided further, That the Secretary may use alternative mechanisms in lieu of Administrative Law Judge review:</i>	Authorizes \$129,000,000 of this appropriation to be used for processing Medicare appeals under BIPA sections 521 and 522, including Medicare hearings transferred from the Social Security Administration. Provides the Secretary with flexibility in the adjudication of Medicare hearings.
<i>Provided further, That the Secretary of Health and Human Services is directed to collect fees in fiscal year 2004 from Medicare+Choice organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.</i>	Authorizes the collection of fees from Medicare+Choice organizations for costs related to enrollment, dissemination of information, and certain counseling and assistance programs.

PROGRAM MANAGEMENT

PROGRAM MANAGEMENT APPROPRIATION SUMMARY

Current Law

Activity	2002 Actual 1/	2003 President's Budget 2/	2004 Estimate
Medicare Operations			
Appropriation	\$1,534,500,000	\$1,675,084,000	\$1,776,889,000
Comparability Adjustment (Appeals) 3/	\$73,000,000	\$73,000,000	=
Enacted Rescission (P.L. 107-116/206)	~~(\$2,500,000)~~	=	=
Subtotal,	\$1,605,000,000	\$1,748,084,000	\$1,776,889,000
Federal Administration			
Appropriation	\$531,700,000	\$562,497,000	\$580,571,000
Enacted rescission (P.L. 107-116/206)	~~(\$1,215,000)~~	=	=
Subtotal,	\$530,485,000	\$562,497,000	\$580,571,000
State Survey & Certification			
Appropriation	\$256,397,000	\$247,647,000	\$247,647,000
Enacted rescission (P.L. 107-116/206)	~~(\$3,312,000)~~	=	=
Subtotal,	\$253,085,000	\$247,647,000	\$247,647,000
Research, Demonstration, & Evaluation			
Appropriation	\$118,201,000	\$28,400,000	\$63,400,000
Enacted rescission (P.L. 107-116/206)	~~(\$1,000,000)~~	=	=
Subtotal,	\$117,201,000	\$28,400,000	\$63,400,000
Revitalization Plan			
Appropriation	=	=	\$65,000,000
Subtotal,	=	=	\$65,000,000
Appropriation/Budget Authority	\$2,505,771,000	\$2,586,628,000	\$2,733,507,000

1/ The FY 2002 actual column reflects final (net) appropriation after all rescissions, transfers and reprogrammings.

2/ This column reflects the current estimate for FY 2003. Appropriated funds in the FY 2003 President's budget were \$2,538,330,000.

3/ The fiscal years 2002 and 2003 columns include a \$73.0 million comparability adjustment relating to the costs of processing Medicare appeals pursuant to the Benefits Improvement and Protection Act of 2000 (BIPA).

PROGRAM MANAGEMENT

PROGRAM MANAGEMENT APPROPRIATION SUMMARY

Proposed Law

Activity	2002 Actual 1/	2003 President's Budget 2/	2004 Estimate
Medicare Operations 3/	\$1,605,000,000	\$1,748,084,000	\$1,776,889,000
Approp. Offset, Prop. Law 4/	=	(\$130,000,000)	(\$201,000,000)
Approp., Net Prop. Law	\$1,605,000,000	\$1,618,084,000	\$1,575,889,000
User Fees, Prop. Law 4/	=	\$130,000,000	\$201,000,000
Subtotal, Approp.+ P.L. User Fees	\$1,605,000,000	\$1,748,084,000	\$1,776,889,000
Federal Administration	\$530,485,000	\$562,497,000	\$580,571,000
Approp. Offset, Prop. Law	=	=	=
Approp., Net Prop. Law	\$530,485,000	\$562,497,000	\$580,571,000
User Fees, Proposed Law	=	=	=
Subtotal, Approp.+ P.L. User Fees	\$530,485,000	\$562,497,000	\$580,571,000
State Survey & Certification	\$253,085,000	\$247,647,000	\$247,647,000
Approp. Offset, Prop. Law	=	=	=
Approp., Net Prop. Law	\$253,085,000	\$247,647,000	\$247,647,000
User Fees, Prop. Law	=	=	=
Subtotal, Approp.+ P.L. User Fees	\$253,085,000	\$247,647,000	\$247,647,000
Research, Demonstration & Evaluation	\$117,201,000	\$28,400,000	\$63,400,000
Approp. Offset, Prop. Law	=	=	=
Approp., Net Prop. Law	\$117,201,000	\$28,400,000	\$63,400,000
User Fees, Proposed Law	=	=	=
Subtotal, Approp.+ P.L. User Fees	\$117,201,000	\$28,400,000	\$63,400,000
Revitalization Plan	=	=	\$65,000,000
Approp. Offset, Prop. Law	=	=	=
Approp., Net Prop. Law	=	=	\$65,000,000
User Fees, Proposed Law	=	=	=
Subtotal, Approp.+ P.L. User Fees	=	=	\$65,000,000
Subt. Approp., Net Prop. Law	\$2,505,771,000	\$2,456,628,000	\$2,532,507,000
Subt. User Fees, Prop. Law 4/	=	\$130,000,000	\$201,000,000
Total Approp. + P.L. User Fees	\$2,505,771,000	\$2,586,628,000	\$2,733,507,000

1/ The FY 2002 actual column reflects final (net) appropriation after all rescissions, transfers and reprogramming.

2/ This column reflects the current estimate for FY 2003. Appropriated funds in the FY 2003 President's budget were \$2,538,330,000.

3/ The fiscal years 2002 and 2003 columns include a \$73.0 million comparability adjustment relating to the costs of processing Medicare appeals pursuant to the Benefits Improvement and Protection Act of 2000 (BIPA).

4/ If enacted, the user fees proposed in fiscal years 2003 and 2004 will offset our Program Management appropriation on a dollar-for-dollar basis, so that our overall program level remains unchanged.

PROGRAM MANAGEMENT

Proposed Legislation Summary

The CMS proposes new financing mechanisms totaling \$201.0 million in FY 2004. These legislative proposals, and the estimated dollars associated with each, where applicable, are as follows:

PROGRAM MANAGEMENT**Medicare Operations User Fees (\$201,000,000)****Charge providers who forward duplicate or unprocessable claims \$2.50 per claim. (\$195,000,000)**

Providers who submit duplicate claims or claims with inaccurate or insufficient information are imposing an unnecessary workload on the claims processing system. In many cases, providers submit duplicate claims because they become impatient waiting for payment.

CMS and its contractors go to great lengths to ensure providers are aware of billing requirements and the need to submit accurate claims. Charging a fee would heighten provider awareness of these issues and deter this type of action. The fees received from this activity would be credited to CMS's Program Management appropriation. CMS assumes it will begin collecting this fee on March 1, 2003. The FY 2004 estimate cited above reflects a full year of collections as well an increase in the user fee from \$1.50 to \$2.50.

Charge providers a \$50 filing fee for an appeal filed under CMS's new qualified independent review process. (\$6,000,000)

CMS proposes a \$50 user fee for providers who file appeals with the new qualified independent contractors (QIC) mandated by BIPA section 521. This fee is expected to raise \$6 million in the first year. These funds will be used to develop an integrated, electronic case control system that will track the Medicare appeals. This new system will allow for accurate record keeping and improve the efficiency of the appeals process. No fee will be charged to beneficiaries filing appeals. The fees received from this activity will be credited to CMS's Program Management appropriation.

PROGRAM MANAGEMENT

Medicare Operations

Authorizing Legislation - Social Security Act, Title XVIII, Sections 1816 and 1842, 42 U.S.C. 1395.

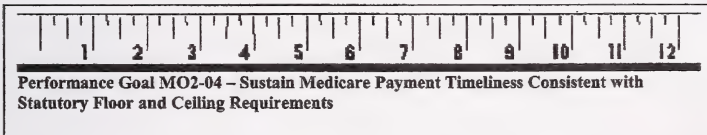
Medicare Operations Summary Table

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
Appropriation/B.A.	\$1,534,500,000	\$1,675,084,000	\$1,776,889,000	+\$101,805,000
Rescissions:				
P.L. 107-116	-500,000			
P.L. 107-206	-2,000,000			
Adjustment for Comparability:				
Appeals	+73,000,000	+73,000,000	---	-73,000,000
Net Appropriation/ B.A. (Comparable)	\$1,605,000,000	\$1,748,084,000	\$1,776,889,000	+\$28,805,000
Direct FTEs: HIPAA	---	---	10	+10

PURPOSE AND METHOD OF OPERATIONS

CMS's FY 2004 budget request for Medicare Operations is \$1,776.9 million, an increase of \$28.8 million above the comparable FY 2003 President's budget request. This level of funding will enable CMS to continue serving approximately 41 million Americans who depend on the Medicare program for their health care coverage.

It will allow CMS's Medicare contractors to meet the contractual responsibilities and expectations set forth by the Administration, as well as by the public, including paying claims in a timely, accurate, and fiscally responsible manner. Fiscal intermediaries (FIs) make payments to providers of services under Part A of the Medicare program. Carriers process claims and make payments to beneficiaries and providers under Part B of the Medicare program. CMS monitors and oversees all Medicare contractor activities and reviews contractor performance in paying claims and serving beneficiaries.



PROGRAM MANAGEMENT

This funding level will also allow CMS to make significant progress in a number of areas including:

- Implementing requirements of recent legislation, particularly provisions of the Benefits Improvement and Protection Act (BIPA) of 2000 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996; and
- Continuing a national ad campaign and 1-800-MEDICARE call center under the National *Medicare & You* Education Program.

CMS has included budget estimates for each of the activities described in the Medicare Operations chapter of this justification. This budget funds many workloads such as fee-for-service claims processing, inquiries, and appeals that are difficult to project two years in advance. It also funds many legislatively mandated activities and administration priorities the costs of which also change over a two-year period. Therefore, actual expenditures may differ from these estimates. CMS will keep Congress apprised as expenditures change.

PROPOSED LEGISLATION SUPPORTING MEDICARE OPERATIONS

The FY 2004 Medicare Operations budget includes two financing proposals totaling \$201.0 million. Enactment of these user fees is offsetting, and will reduce CMS's Program Management request by \$201.0 million.

Charge providers who forward duplicate or unprocessable claims \$2.50 per claim. (\$195,000,000)

Providers who submit duplicate claims or claims with inaccurate or insufficient information are imposing an unnecessary workload on the claims processing system. In many cases, providers submit duplicate claims because they become impatient waiting for payment.

CMS and its contractors go to great lengths to ensure providers are aware of billing requirements and the need to submit accurate claims. Charging a fee would heighten provider awareness of these issues and deter this type of action. The fees received from this activity would be credited to CMS's Program Management appropriation. CMS assumes it will begin collecting this fee on March 1, 2003. The FY 2004 estimate cited above reflects a full year of collections as well an increase in the user fee from \$1.50 to \$2.50.

PROGRAM MANAGEMENT

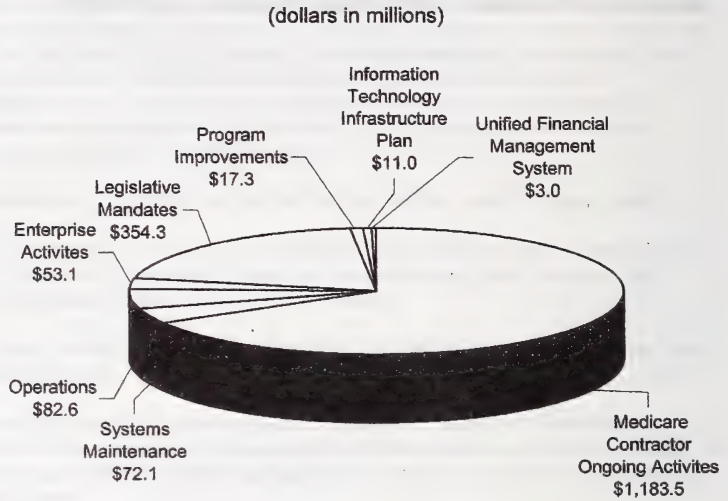
Charge providers a \$50 filing fee for an appeal filed under CMS's new qualified independent review process. (\$6,000,000)

CMS proposes a \$50 user fee for providers who file appeals with the new qualified independent contractors (QIC) mandated by BIPA section 521. This fee is expected to raise \$6 million in the first year. These funds will be used to develop an integrated, electronic case control system that will track the Medicare appeals. This new system will allow for accurate record keeping and improve the efficiency of the appeals process. No fee will be charged to beneficiaries filing appeals. The fees received from this activity will be credited to CMS's Program Management appropriation.

PROGRAM MANAGEMENT

MEDICARE OPERATIONS SUMMARY

As shown in the pie chart below, the majority of the Medicare Operations request funds the contractors' ongoing activities in FY 2004. More than ever before, the funding required to complete activities required by legislation reflects a large piece of the pie. The remainder of the request will be used for information technology costs, other operations costs, and program improvements.



PROGRAM MANAGEMENT

RATIONALE FOR THE BUDGET REQUEST**MEDICARE CONTRACTOR ONGOING ACTIVITIES: \$1,183.5 million**

Approximately 67 percent of the Medicare Operations budget is categorized as Medicare contractor ongoing activities. This category includes funding provided to CMS's Medicare contractors in order to process their negotiated workloads. These workloads include paying claims, handling appeals, responding to inquiries, enrolling providers and suppliers, educating providers and beneficiaries, enrolling and overseeing participating physicians, recovering overpayments, and others.

This request asks for a level of funding that will allow the Medicare contractors to process their workloads accurately, in a timely manner, and in accordance with CMS's standard program requirements. This request reflects an increase of \$55.3 million above the FY 2003 President's budget level.

The table below displays each of the major activities included in this category and the funding levels associated with each:

(\$ in millions)	FY 2003 P.B.	FY 2004 Estimate	Difference
Bills/Claims Payment	\$702.2	\$749.8	+\$47.6
Provider Reimbursement	42.5	42.5	--
Appeals	117.4	136.7	+19.3
Inquiries	216.6	240.0	+23.4
Provider Education and Training (PET)	41.5	6.5*	-35.0
Participating Physician/Supplier Program (PARDOC)	8.0	8.0	--
Total, On-Going Activities	\$1,128.2	\$1,183.5	+\$55.3

* An additional \$30 million will be funded through the Medicare Integrity Program (MIP).

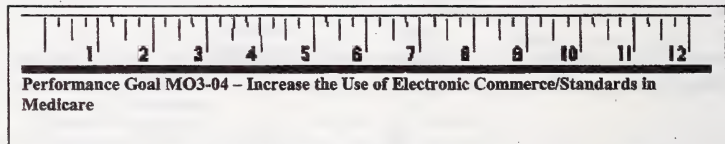
Bills/Claims Payments: \$749.8 million

This category reflects the Medicare contractors' costs of processing and paying Part A bills and Part B claims including electronic data processing, contractor personnel, postage, printing, etc. It also includes the cost of enrolling providers in the Medicare program.

PROGRAM MANAGEMENT

The increase of \$47.6 million above the FY 2003 President's budget reflects an anticipated increase in the number of claims. CMS estimates that the Medicare contractors will pay 1,097 million Medicare claims in FY 2004 -- 179 million Part A and 918 million Part B claims. This volume reflects an increase of 110 million claims, about 11 percent over the FY 2003 President's budget level. Medicare contractors experienced a surge of claims, especially Part B claims, in FY 2002. Therefore, we estimate that claims volume will increase more than in prior years.

The FY 2004 unit costs are expected to decrease when compared to the FY 2003 President's budget estimates. Effective October 1, 2003, HIPAA requires that claims be submitted electronically. Therefore, we expect that even more providers will submit their fee-for-service claims electronically, resulting in a lower processing cost for Medicare contractors.



The table on the following page displays workload and unit cost data from FY 1991 through FY 2004. Historically, the Part A unit cost included inquiries and provider education and training (PET); both unit costs included systems maintenance costs. Beginning in FY 1998, at CMS's request, the contractors began to report these items separately from the unit cost. CMS has re-calculated the unit costs from FY 1998 forward, eliminating the non-claims items cited above. (These activities and their costs are now displayed separately in later sections of this chapter.)

PROGRAM MANAGEMENT

CLAIMS PROCESSING AND WORKLOAD PROCESSING
1991 to 2004
Claims Processing Unit Costs (in Current Dollars)

	FY 1991 Actual	FY 1992 Actual	FY 1993 Actual	FY 1994 Actual	FY 1995 Actual	FY 1996 Actual	FY 1997 Actual
Part A	\$1.67	\$1.60	\$1.39	\$1.40	\$1.29	\$1.20	\$1.11 ¹
Part B	\$1.15	\$1.05	\$0.96	\$0.89	\$0.82	\$0.74	\$0.68
	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual	FY 2001 Actual	FY 2002 Enacted	FY 2003 Pres.Bud.	FY 2004 Estimate
Part A	\$0.82	\$0.76	\$0.86	\$0.86	\$0.87	\$0.89	\$0.87
Part B	\$0.64	\$0.60	\$0.63	\$0.61	\$0.64	\$0.67	\$0.65

1/ FY 1997 and prior years include Part A inquiries, Part A provider education and training (PET), and shared systems maintenance costs.

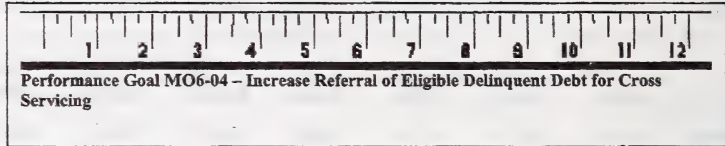
Claims Workload (Processed Claims in Millions)

	FY 1991 Actual	FY 1992 Actual	FY 1993 Actual	FY 1994 Actual	FY 1995 Actual	FY 1996 Actual	FY 1997 Actual
Part A	91.8	101.1	109.6	120.6	133.1	142.1	150.0
Part B	501.4	546.8	574.9	615.1	646.5	665.6	692.7
	FY 1998 Actual	FY 1999 Actual	FY 2000 Actual	FY 2001 Actual	FY 2002 Enacted	FY 2003 Pres.Bud.	FY 2004 Estimate
Part A	149.0	147.8	150.8	158.6	165.7	173.5	179.2
Part B	710.8	719.6	740.2	772.0	832.6	813.5	917.9

PROGRAM MANAGEMENT

Provider Reimbursement: \$42.5 million

As part of claims processing activities, contractors also perform provider reimbursement services, which include establishing and adjusting interim rates to ensure proper payment to providers, maintaining provider-specific permanent files, reporting and collecting provider overpayments, and identifying non-Medicare secondary payer delinquent debt which is eligible for referral to the Department of Treasury for cross-servicing and offset, consistent with the Debt Collection Improvement Act of 1996. This request is the same as the FY 2003 President's budget request.

**On-Going Appeals: \$136.7 million**

The Medicare appeals process affords beneficiaries, providers, and suppliers an opportunity to dispute initial determinations made by contractors to deny claims. The current estimate for FY 2004 is \$136.7 million, \$19.3 million above the FY 2003 President's budget. This increase is consistent with trends in previous years.

There are numerous reasons for the increase in appeals volumes each year. First, the increase in the number of beneficiaries and claims results in an increase in appeals. Second, denials due to lack of documentation have increased recently. Third, CMS's emphasis on reducing fraud, waste, and abuse, coupled with a multi-million dollar increase in funding for the Medicare Integrity Program, has increased the number of medical reviews conducted by the Medicare contractors. This, in turn, has increased the number and complexity of appeals. Fourth, program changes and policy changes, such as the implementation of new prospective payment systems and the expansion of the rights of States to appeal on behalf of Medicare beneficiaries who are also eligible for Medicaid, have also increased the number and complexity of appeals.

The table on the following page displays workloads, unit costs, and total costs for processing appeals work.

PROGRAM MANAGEMENT

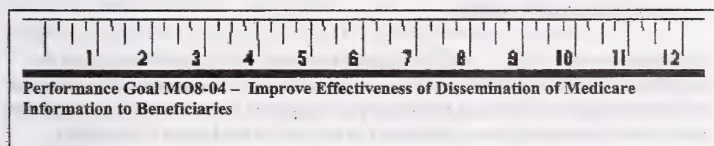
Medicare Contractor Appeals Workloads

	FY 2002 Estimated Actual	FY 2003 President's Budget	FY 2003 Current Estimate	FY 2004 Estimate
<u>Workload</u>				
Part A	561,000	450,000	583,000	607,000
Part B	<u>6,703,000</u>	<u>6,920,000</u>	<u>6,971,000</u>	<u>7,250,000</u>
Total	7,264,000	7,370,000	7,554,000	7,857,000
<u>Unit Costs</u>				
Part A	\$48.43	\$60.06	\$50.36	\$52.38
Part B	\$13.38	\$13.06	\$13.91	\$14.47
<u>Total Costs</u> <u>(\$ in Millions)</u>				
Part A	\$27.2	\$27.0	\$29.4	\$31.8
Part B	<u>\$89.7</u>	<u>\$90.4</u>	<u>\$97.0</u>	<u>\$104.9</u>
Total	\$116.9	\$117.4	\$126.4	\$136.7

Inquiries: \$240.0 million

This request includes the cost of answering both provider and beneficiary inquiries at the Medicare contractors, as well as funding for beneficiary outreach and education. These costs have been increasing, most likely due to increased activity in both the Medicare Integrity Program, especially medical reviews, and the National *Medicare & You* Education Program. In addition, provider inquiries have increased in the past couple of years, possibly as a result of having toll-free lines at the contractors.

The FY 2003 request, an increase of \$23.4 million or 11 percent over the FY 2003 President's budget request, is consistent with trends in previous years and reflects the level of funding needed to support this essential service.



PROGRAM MANAGEMENT

Provider Education and Training (PET): \$6.5 million

Physicians, providers, and suppliers who participate in the Medicare program rely on CMS to provide them with timely, relevant, and understandable information in order to better serve Medicare beneficiaries. One of CMS's priorities is to create a culture that is open, accessible, and responsive to our partners, making it easier for them to understand our programs and navigate our organization. The on-going PET activities directly support this mission. A strong, effective PET program also helps reduce claims processing errors and the additional work (e.g., inquiries, appeals, overpayment collections) that flows from these errors. On-going PET activities include conducting seminars, workshops, and classes to educate and train providers; coordinating a PET advisory group; developing and issuing bulletins and newsletters; and maintaining and expanding an Internet website and electronic mailing lists. In FY 2004, PET will be partially funded through the Medicare Integrity Program (MIP), focusing on assisting providers to avoid and detect waste, fraud and abuse.

Participating Physician/Supplier Program: \$8.0 million

This program strives to reduce the impact of rising medical costs on beneficiaries by increasing the number of physicians and suppliers who participate in the Medicare program and by enforcing the charge limit. This request covers the costs of conducting the annual enrollment process plus some monitoring of limiting charge compliance and limited distribution of information to participating physicians.

SYSTEMS MAINTENANCE: \$72.1 million

This request provides funding for computer software services, e.g., systems modifications, design and development of new code, applications testing, etc. CMS needs to keep its systems current with statutory and regulatory requirements. This request reflects a decrease of \$12.9 million below the FY 2003 President's budget level.

OPERATIONS: \$82.6 million

This category funds essential activities that support the continued, uninterrupted operation of the Medicare fee-for-service program. This request reflects a decrease of \$20.3 million below the FY 2003 President's budget level. The FY 2004 request includes:

Non-Renewals: \$20.0 million

This request includes \$20.0 million for non-renewals, \$10.0 million less than the FY 2003 President's budget. CMS incurs several costs when a Medicare contractor leaves the program, including severance pay, payments for excess capacity, and one-time costs of preparing other contractors to absorb the workloads of departing

PROGRAM MANAGEMENT

contractors. Although CMS cannot know which or how many contractors will leave the Medicare program in a given year, it must be prepared for a certain number of non-renewals each year.

Information Technology: \$46.4 million

The FY 2004 request includes information technology funding that CMS pays for directly, such as the costs of the common working file and data center operations. The request includes an additional \$9.0 million above the FY 2003 President's budget to cover increased independent testing of Medicare standard systems and increased costs for Medicare claims data systems.

Systems Transitions: \$6.4 million

This item funds the costs of converting Medicare contractors to the selected standard claims processing systems. CMS's goal is to reduce the multiple systems currently in use to a total of three systems: one for the fiscal intermediaries, one for the carriers, and one for the durable medical equipment regional carriers (DMERC). A smaller number of systems will provide a more controlled processing environment and, ultimately, reduce the costs associated with maintaining multiple systems. Completion of transitions is needed before the Healthcare Integrated General Ledger and Accounting System (HIGLAS) can be fully implemented. This request represents a decrease of \$17.2 million below the FY 2003 President's budget.

Provider Toll-Free Lines: \$7.0 million

CMS will continue to offer toll-free lines to providers so they can receive quick, accurate answers to questions about billing and claims processing and other Medicare-related issues. Previously, the providers paid long-distance phone charges to call the Medicare contractors. This is another step in CMS's efforts to reduce payment errors, ease the financial burden on providers, and support physicians as they care for Medicare beneficiaries. This funds the toll-free lines only, and does not include the cost for the customer service representatives, which is shown in the inquiries section. This request is the same as the FY 2003 President's budget.

Other Operational Costs: \$2.8 million

This category includes funds for printing Medicare forms, maintaining the unique physician identification number (UPIN) registry, and leasing space for document storage. This request is the same as the FY 2003 President's budget.

PROGRAM MANAGEMENT

ENTERPRISE-WIDE ACTIVITIES: \$53.1 million

This request provides funding for CMS's on-going critical systems infrastructure that supports on-going operations. Included under this category is funding to support the Consolidated Information Technology Infrastructure Contract (CITIC), the Medicare Data Communications Network (the secure telecommunications network that supports transaction processing and file transmission), hardware maintenance and software licensing, and data communication services. This request reflects a decrease of \$6.2 million below the FY 2003 President's budget request.

CHANGES REQUIRED BY LEGISLATION: \$354.3 million

This category includes funding for activities mandated by legislation, including the Benefits Improvement and Protection Act (BIPA) of 2000, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Act (BBA) of 1997, the Chief Financial Officers Act, the Federal Financial Management Improvement Act, and others. Funding for legislative mandates in FY 2004 increases by a total of \$84.6 million above the FY 2003 President's budget. Most of this increase reflects funding needed for BIPA provisions, HIPAA provisions, and the Healthcare Integrated General Ledger and Accounting System (HIGLAS).

HIPAA Administrative Simplification: \$32.8 million

HIPAA enacted administrative simplification provisions intended to reduce the costs and administrative burden on the health care industry by standardizing the electronic transmission of certain transactions. CMS has a national leadership role in implementing three major administrative simplification provisions: the National Provider Identifier, the National Health Plan Identifier, and the transactions and code sets. The FY 2004 request includes several information technology costs, including:

- ongoing design and development of the information system that will be used to enumerate health plans and health care providers with unique identifiers for use in transactions;
- beginning to assign unique identifiers to providers who are covered entities -- assignment of identifiers is a multi-year project;
- implementing local systems changes, new standards, and modifications at the fiscal intermediaries, carriers, and DMERCS; and
- testing with late providers.

In addition, CMS's budget sets aside \$10.0 million in Medicare Operations for start-up costs for part of FY 2004 to develop and implement the HIPAA administrative simplification enforcement program for security, transactions, code sets, and identifiers. Start-up costs will consist of building the staff, publishing enforcement regulations,

PROGRAM MANAGEMENT

developing enforcement procedures, and implementing systems. CMS anticipates using a combination of Federal and contractor FTEs. In addition, CMS will conduct outreach to explain to the health care industry the enforcement responsibilities and penalties noncompliance may warrant. Following these activities, CMS will be positioned to begin accepting enforcement complaints at an expected volume of approximately one percent of all HIPAA-covered entities. FY 2005 would be the first full year of enforcement operations.

In total, the request for HIPAA administrative simplification reflects a decrease of \$31.3 million below the FY 2003 President's budget request.

HIPAA Privacy Regulation: \$2.3 million

This HIPAA requirement strengthens the basic tenets of the Privacy Act and extends it to the private sector. CMS's request, \$8.7 million less than the FY 2003 President's budget request, will allow us to continue training for CMS staff, contractors, and partners and to test, verify, and validate our privacy implementation activities.

BIPA Section 521: \$126.0 million

BIPA section 521 significantly revises the Medicare fee-for-service appeals process. Key changes include new independent review entities, a uniform process for handling Part A and Part B appeals, a new right to an expedited appeal, much shorter time frames at all appeals levels, an "escalator" clause, and reduced amounts in controversy for Part B appeals.

CMS's request includes funding to implement an amended version of BIPA section 521 which reflects the following changes:

- Allow CMS 16 months, following the receipt of funding, to implement BIPA reforms. We estimate that 16 months is the appropriate amount of time needed to award contracts to qualified independent contractors (QICs) and to proceed with rulemaking.
- Enable CMS to contract with fewer than 12 QICs. We believe that no fewer than 4 QICs will maximize administrative efficiency.
- Increase decision-making timeframes at all levels of the appeals process, from 30 days to 90 days for Part A appeals and from 30 days to 45 days for Part B appeals at the Medicare contractors; from 30 days to 60 days for QIC hearings; and from 90 days to 180 days for administrative law judge and Departmental Appeals Board hearings. More realistic timeframes should help reduce the number of appeals filed at the higher, more costly adjudication levels.

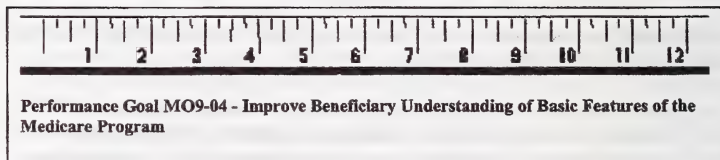
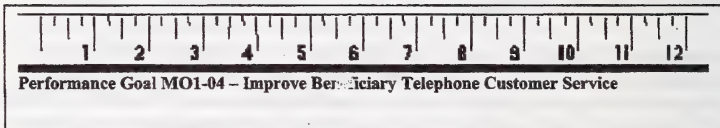
This request also includes funding to transfer the Medicare hearings function from the Social Security Administration (SSA). SSA's administrative law judges (ALJs)

PROGRAM MANAGEMENT

currently hear Medicare hearings. In order to succeed with this new function, CMS will need the authority to use administrative mechanisms other than ALJs, such as hearings officers. The additional FTEs needed to process this work are not reflected in the totals shown throughout this document.

National Medicare & You Education Program (NMEP): \$122.0 million

This request will enable CMS to fund activities that educate beneficiaries about Medicare and their health plan choices. CMS will devote resources to the State Health Insurance Assistance Program, a program that provides counseling support directly to beneficiaries. In addition, funding will be used to support the operation of additional information channels, such as toll-free telephone services via 1-800-MEDICARE, Internet services through www.medicare.gov, a publicity campaign, and the *Medicare & You* handbook, enabling beneficiaries to make more informed health care choices. The FY 2004 request for the portion of the NMEP initiative funded via the Program Management appropriation is the same as the FY 2003 President's budget request. For more information, refer to the NMEP section in the supporting information tab.



Other CMS projects required by legislation include:

Healthcare Integrated General Ledger and Accounting System (HIGLAS): \$53.3 million

The Healthcare Integrated General Ledger and Accounting System (HIGLAS) project is part of the Department's Unified Financial Management System (UFMS). By integrating the Department's financial management structure, the UFMS will achieve greater economies of scale, eliminate duplication, mitigate security risks, and provide more timely and accurate information for management purposes.

PROGRAM MANAGEMENT

With a unified system, CMS and the rest of the Department will have uniform business rules, data standards, and accounting policies and procedures for more efficient implementation as administrative support functions are incorporated. This effort will move CMS, along with the rest of the Department, toward the Secretary's goal of one HHS and, at the same time, support the President's Management Agenda initiative to improve financial performance. It will also address the Inspector General's concerns regarding a fully functioning integrated financial system for the Department.

CMS's Medicare contractors lack a uniform financial management system to account for the billions of dollars spent on Medicare benefits each year. The current process is inadequate for detecting and collecting money owed to the Medicare trust funds; retaining a clean opinion on financial statements without expensive, alternative efforts; and complying with financial management statutory requirements, including the Joint Financial Management Improvement Program, the Clinger-Cohen Act, and the Federal Financial Management Improvement Act. HIGLAS will ensure that CMS can meet all of these objectives by replacing the multiple processes currently in use with a uniform accounting system.

HIGLAS represents a major information technology investment that will require several years to complete. In support of this initiative, CMS is requesting \$53.3 million for Medicare Operations in FY 2004, an increase of \$6.3 million from the FY 2003 President's budget.

Financial Statement Audits: \$7.9 million

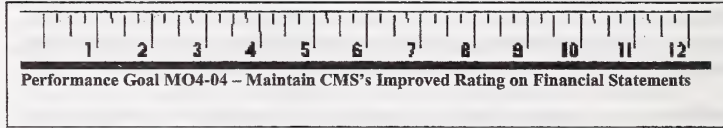
This request, the same level as the FY 2003 President's budget, includes funds for audit activities including the annual audit required by the Chief Financial Officers (CFO) Act of 1990. Federal agencies' financial statements are audited to reassure the public that they have fairly and accurately represented their financial condition. A clean and timely audit opinion on these statements is essential if decision-makers within the agency and at OMB and Congress are to use the information to make their decisions.

The CFO Act requires that CMS—the largest operating division in the Department—be audited. As one of the four Federal agencies that are significant to the government-wide consolidated statement each year, HHS will continue its considerable efforts to retain its clean opinion, while meeting the additional challenge of the accelerated time frames established by the Reports Consolidation Act. The Healthcare Integrated General Ledger Accounting System (HIGLAS) is the long-term solution to these challenges but, in the meantime, significant manual effort and upgrading of the automated consolidated financial statements is necessary.

In addition, CMS has increased efforts to expand and enhance financial analysis. Its trend analysis and risk assessments of financial data will help to more readily detect problems and variances so CMS can identify potential areas of risk and then take action

PROGRAM MANAGEMENT

on them. To accomplish the goal of a clean and timely opinion, HHS and CMS will work with and rely on the Office of Inspector General and certified public accounting firms to conduct the audits.



Changes Related to Managed Care: \$10.0 million

The BBA requires that an independent contractor review Medicare managed care appeals. This FY 2004 request includes funding for managed care reconsiderations. In addition, the settlement agreement of the *Grijalva* lawsuit shifts the burden of adjudicating certain managed care appeals, i.e., discharges from skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs), from Medicare managed care organizations (MCOs) to an independent review entity (IRE) under contract with CMS. Under this new appeals process, an MCO would be required to give a beneficiary notice prior to terminating SNF, HHA, or CORF services. The beneficiary may file for an expedited review with the IRE. This request is based on CMS's experience with the IRE that currently processes its Medicare managed care appeals workload. This request is \$2.7 million less than the FY 2003 President's budget request.

PROGRAM IMPROVEMENTS: \$17.3 million

This category, which decreases \$1.7 million from the FY 2003 President's budget level, includes projects that improve the Medicare program, increase efficiency, and enhance relations with our stakeholders. These activities include:

Medicare-Endorsed Prescription Drug Card: \$5.0 million

CMS is requesting funding for start-up costs in FY 2004 for the Medicare-endorsed prescription drug card. Activities would include: technical support for the start-up of the consortium, such as developing a design for the enrollment exclusivity system and for the price comparison web site (which will reduce implementation time by 6 months); development of marketing guidelines for program sponsors to follow in producing marketing materials; review of program-sponsor marketing materials; initial development of a complaints tracking system; technical support for starting up a corrective actions process; and social marketing research to understand beneficiary attitudes and behaviors toward drug discount card programs under Medicare's

PROGRAM MANAGEMENT

endorsement to inform our education and assistance efforts. This is a new activity not included in the FY 2003 President's budget request.

Physician Regulatory Issues Team (PRIT): \$5.0 million

CMS developed the Physician Regulatory Issues Team (PRIT) in response to physician complaints about the Medicare regulatory burden. CMS's plans include the following activities to investigate and address physicians' concerns:

- improve physician understanding of the Medicare program, including developing and maintaining a dedicated internet site on cms.hhs.gov that will provide essential information on Medicare rules, reimbursement, and compliance;
- collect issues and develop solutions to regulatory obstacles or unnecessary physician burden, including legislative changes, policy changes, enhanced educational outreach, training and publications; and
- continue to obtain input from practicing physicians by querying them about their daily experience with the Medicare program as they care for beneficiaries.

This request is the same as the FY 2003 President's budget request.

Medicare Learning Network Support (MedLearn): \$4.0 million

MedLearn is a comprehensive program that communicates with health care professionals via mass media, including print, Internet, videos, and satellite network resources, as well as face-to-face instructions. It also includes coordination of feedback mechanisms to ensure that CMS is giving the provider community the information it wants and needs. This request is the same as the FY 2003 President's budget request.

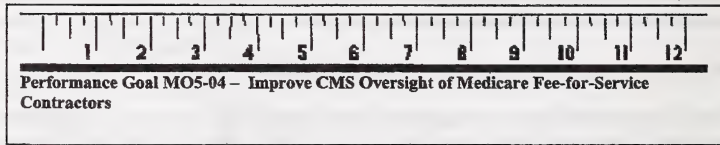
Investments in Information Technology: \$2.3 million

This category includes funding for strengthening information technology security compliance at the Medicare contractors and several smaller activities. This request is \$2.7 million less than the FY 2003 President's budget request.

Improve Medicare Contractor Oversight: \$1.0 million

CMS remains focused on continuing this comprehensive initiative to improve contractor oversight. In FY 2004, CMS will develop, refine, and improve the methodology for populating review teams, make overall improvements to the Contractor Performance Evaluation (CPE) review protocols, and identify a methodology for drawing CPE review samples. This request also funds the Contractor Management Information System (CMIS). This request is the same as the FY 2003 President's budget request.

PROGRAM MANAGEMENT



INFORMATION TECHNOLOGY ENTERPRISE INFRASTRUCTURE FUND:
\$11.0 million

CMS's request includes \$11.0 million to support Departmental efforts to improve the HHS information technology (IT) enterprise infrastructure. This funding will support an enterprise approach to investing in key IT infrastructure, such as security and network modernization, investments which will enable HHS programs to carry out their missions more securely and at a lower cost. Agency funds will be combined with resources in the IT Security and Innovation Fund to promote collaboration in planning and project management and to achieve common goals, such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software. This request is the same as the FY 2003 President's budget request.

UNIFIED FINANCIAL MANAGEMENT SYSTEM (UFMS): \$3.0 million

The UFMS will be implemented to replace five legacy accounting systems currently used across the Operating Divisions. The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. It will also promote the consolidation of accounting operations and thereby reduce substantially the cost of providing accounting services throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable HHS senior managers and program administrators to make more timely and informed decisions regarding their operations. CMS is requesting \$3.0 million to support this effort in FY 2004.

PROGRAM MANAGEMENT

APPROPRIATIONS HISTORY:

The table below displays Medicare Operations funding levels for the past 5 years.

**Medicare Operations
Appropriations History ***

Fiscal Year	Appropriation
1999	\$1,265,081,000
2000	\$1,239,000,000
2001	\$1,356,436,000
2002	\$1,532,000,000
2003 P.B.	\$1,675,084,000

* Reflects non-comparable values.

SUMMARY:

CMS's FY 2004 budget request for Medicare Operations is \$1,776.9 million which will enable CMS's Medicare contractors to fulfill their growing contractual responsibilities and expectations, including paying claims, handling appeals, responding to inquiries, enrolling providers and suppliers, educating providers and beneficiaries, along with many other activities. In addition, it will allow CMS to address the significant increase in activities required by legislation. This level of funding will enable CMS to continue serving approximately 41 million Americans who depend on the Medicare program for their health care coverage.

PROGRAM MANAGEMENT

Federal Administration

Authorizing Legislation - Reorganization Act of 1953.

Federal Administration Summary Table

	2002 Actual	2003 President's Budget 1/	2004 Estimate	Increase Or Decrease
Appropriations/B.A.	\$531,700,000	\$562,497,000	\$580,571,000	+\$18,074,000
Rescission: P.L. 107-116	-\$215,000			
Rescission: P.L. 107-206	-\$1,000,000			
Net Appropriation/B.A.	\$530,485,000	\$562,497,000	\$580,571,000	+\$18,074,000
Total FTEs 2/	4,417	4,581	4,398	-183

1/ This column reflects the current estimate for FY 2003. Budget authority requested in the FY 2003 President's budget was \$587,199,000. The current estimate does not reflect \$30.4 million for the proposed accrual payment for retirement and health benefits included in the FY 2003 President's budget. It also restores \$5.7 million in funding for legislative and public affairs staff to remain at CMS.

2/ Funding for additional FTEs is described in the following sections: Medicare Operations, HCFAC and CLIA. Staff resources resulting from the transfer of appeals activities from the Social Security Administration are not included in the FY 2004 estimate.

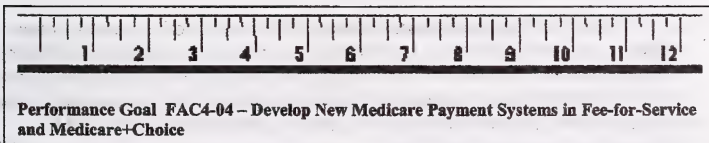
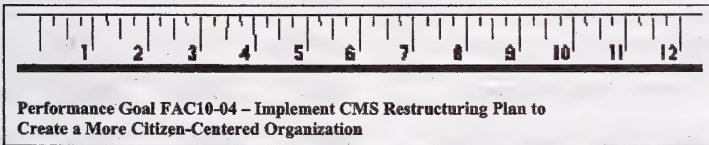
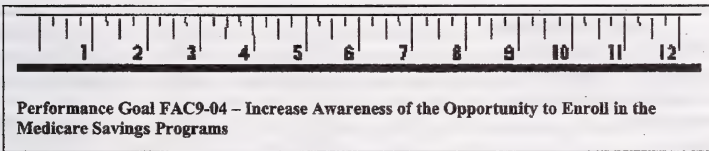
PURPOSE AND METHOD OF OPERATIONS

In FY 2004, approximately 4,486 CMS employees working in Baltimore, Maryland; Washington, DC; and 10 regional offices nationwide will perform many essential activities, including: providing funds to Medicare contractors; developing operating systems used to oversee our programs; managing programs to fight fraud, waste, and abuse; developing cost-effective health care purchasing approaches; monitoring contractor performance; and assisting States with Medicaid and SCHIP issues.

PROGRAM MANAGEMENT

RATIONALE FOR THE BUDGET REQUEST

In an effort to clarify the presentation of the administrative budget, CMS has undertaken a concerted effort to standardize the budget tables and categories to more closely parallel the execution of the budget. This will result in both a more accurate description of activities funded under this budget and a more meaningful display of budgetary information for our stakeholders. The following table reflects the results of this analysis, indicating a level of funding that will allow the agency to upgrade oversight of its programs while improving the way we interact with beneficiaries, providers, and other stakeholders.



PROGRAM MANAGEMENT

Federal Administration Summary
(dollars in millions)

Object of Expense	2002 Operating Plan	2003 President's Budget	2004 Estimate	Percent Change
Fixed Expenses				
Personnel Compensation & Benefits	\$391.2	\$427.8	\$428.8	+0.2%
Rent, Communications & Utilities	18.1	19.5	19.5	---
Single-Site Building Loan	9.8	9.8	9.8	---
Service and Supply Fund	7.1	7.0	7.0	---
Administrative Services	11.2	7.2	7.2	---
Information Technology	41.8	38.6	38.6	---
Subtotal, Fixed Expenses	\$479.2	\$509.9	\$510.9	+0.2%
Variable Expenses				
Inter-Agency Agreements	\$2.8	\$2.2	\$2.2	---
Supplies and Equipment	1.6	1.5	1.5	---
Contracts and Intra-Agency Agreements	22.6	23.5	37.0	+57.4%
Training	2.6	3.2	3.2	---
Travel	9.8	9.0	10.2	+13.3%
Printing and Postage	5.9	6.5	7.5	+15.4%
BIPA Section 522 (Appeals)	0.0	0.0	3.0	---
HIGLAS (IT)	6.0	4.0	3.7	-7.6%
HIPAA Administrative Simplification (IT)	0.0	2.7	0.0	---
HIPAA Security Rule (IT)	0.0	0.0	1.4	---
Subtotal, Variable Expenses	\$51.3	\$52.6	\$69.7	+32.5%
Total, Federal Administration	\$530.5	\$562.5	\$580.6	+3.21%

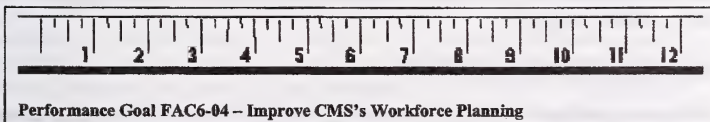
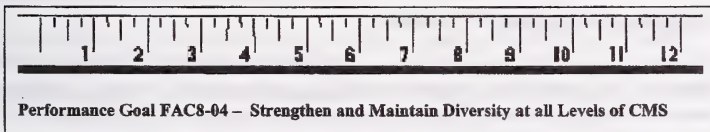
Fixed Expenses**Personnel Compensation and Benefits (\$428.8 million)**

The FY 2004 CMS budget estimate includes \$435.8 million of direct and indirect funding to support 4,486 FTEs. Of this total amount, \$428.8 million in the Federal Administration activity will fund the base pay and benefits for the agency's 4,398 direct FTEs; \$1.0 million from the Medicare Operations account will also support the direct funding of 10 FTEs; and \$6.0 million will support 78 FTEs funded by CLIA reimbursable non-appropriated funds. The pay increase assumption for January 2004 is 2 percent.

PROGRAM MANAGEMENT

Workforce and Succession Planning at CMS

In FY 2004, CMS will save \$6.0 million through the implementation of the President's Management Agenda, which promotes cost savings from consolidating administrative functions, organizational layering to speed decision making processes, implementation of effective workforce planning and human capital management strategies, and adoption of other economies and efficiencies in administrative operations. People are the most significant resource available to leadership in an organization. CMS created and is implementing a strategic human resources (HR) plan to ensure that the agency has the human capital it needs to accomplish its mission. Three of the agency's Government Performance and Results Act (GPRA) goals are to strengthen and maintain diversity at all levels of CMS, improve CMS's workforce planning, and implement a restructuring plan to create a more citizen-centered organization. A key component in accomplishing the agency's HR goals is the development of a comprehensive workforce planning process and automated system. The process includes retirement, retention, and demographic analyses; quantification of the human resources devoted to CMS business functions; and identification of the knowledge and skills required to achieve the agency's strategic goals. The automated system is expected to be fully operational by the end of FY 2003. This will support CMS's efforts to make the best use of the current workforce, more accurately predict immediate and long-term human capital needs, prepare for turnover in an aging workforce, and ultimately satisfy stakeholders by demonstrating that CMS is managing its human resources responsibly. In FY 2004, we project that 2,944 FTEs will staff the central office and 1,542 FTEs will staff the regional offices. The budget authority requested in the FY 2003 President's budget reflects the adjustment for the pay costs associated with the transfer of 60 FTEs from CMS to the Office of the Secretary (OS). The current estimate for the FY 2003 President's budget and the FY 2004 estimate reflect the reinstatement of funding for 60 FTEs in the legislative and public affairs functions to CMS.



PROGRAM MANAGEMENT

**Rent, Communications, and Utilities (\$19.5 million)**

This request includes \$19.5 million to fund facility-operating costs for our single-site facility in Baltimore, Maryland, 10 regional offices, and our Washington, DC, offices. Rent costs for our 10 regional and Washington, DC, offices consist mainly of space rental, utilities, grounds maintenance, security, snow removal, cleaning, trash removal, and painting.

Single-Site Building Loan (\$9.8 million)

Our FY 2004 land and structure request provides funding to pay the General Service Administration (GSA) for the principal and interest on 44 construction loans for our single-site facility in Baltimore, Maryland.

Service and Supply Fund (\$7.0 million)

These funds primarily support the CMS financial management service system (\$3.0 million) and the personnel and payroll systems (\$2.2 million). This request includes \$0.6 million to support the DHHS financial management service system. \$1.2 million supports other funding activities, including the regional mail support, EEO complaint investigations, and other services related to the administrative support of our daily operations.

Administrative Services (\$7.2 million)

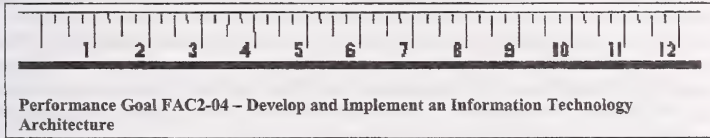
These funds support the physical security of the single-site facility in Baltimore, Maryland, i.e., guard contracts, and the remaining administrative services activities that support the daily operation of CMS's headquarters and regional offices. These activities include: building maintenance and repairs, legal advertisements, medical/health services, job orders, machine repairs, mailroom services, and the Baltimore/DC shuttle.

Information Technology (\$38.6 million)

This request will provide funding for on-going CMS operations of CMS infrastructure, including the Consolidated Information Technology Infrastructure Contract (CITIC), the on-going development and implementation of CMS's enterprise system security initiative, and a number of administrative systems that support grant/contract

PROGRAM MANAGEMENT

administration, financial management, and document management services. This request also supports web-hosting services, satellite services, data management, and a number of Medicaid data systems.



Variable Expenses

Inter-Agency Agreements (\$2.2 million)

The CMS request includes \$2.2 million for inter-agency agreements (IAs). The request includes funds for our largest IA with the Department of Treasury for agency-wide photocopier support for supplies, training, and preventive maintenance. The other large IA is with the Department of Labor to handle the agency's share of annual benefits payments for worker's compensation. CMS has several smaller IAs with the Office of Personnel Management (OPM) for employee services.

Supplies and Equipment (\$1.5 million)

This request provides funds for general office supplies and materials for both our central and regional offices. The CMS has also included funds for furniture, office equipment, and replacement items.

Contracts and Intra-Agency Agreements (\$37.0 million)

On-going activities accomplished at least partially through contracts and intra-agency agreements include, but are not limited to:

Administrative Contracts

The CMS will fund over 100 small administrative contracts and intra-agency agreements. CMS obtains a variety of operational services through contractual arrangements. Examples include: miscellaneous EEO services, conference support, beneficiary and provider outreach, financial and legal services, implementation of the *Olmstead* Supreme Court decision, implementation of the Temporary Assistance for Needy Families (TANF), and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA).

PROGRAM MANAGEMENT

Healthy Start, Grow Smart

The Healthy Start, Grow Smart program aims to print and disseminate a series of 13 informational brochures in English and Spanish to new Medicaid mothers. These brochures are distributed at the time of birth and monthly over the first year of the child's life. Each publication focuses on activities that stimulate infant brain development and build the skills these children need to be successful in school. In addition to these educational suggestions, each Healthy Start pamphlet includes vital health and safety information for new parents. Content for each brochure is tied to the developmental stage of the child at the time it is sent.

CMS estimates that \$13 million will be necessary to run the program for the coming year. These funds will be used primarily for printing costs and postage. This initiative will be fully funded by the Federal Government, but will be operated solely by the States.

State Children's Health Insurance Program (CHIP)

CMS has included funding for improved outreach efforts and targeted assistance to identify eligible children and help their parents with the enrollment process. These funds may be customized to individual state outreach programs.

Balanced Budget Act (BBA)

The FY 2004 request includes funds for ongoing BBA activities and improvements. This request provides funds for quality-of-care activities, improved outreach activities and ongoing, targeted assistance activities.

Other Contractual Activities

CMS's FY 2004 request will fund outreach activities for the Minority Health Initiative (MHI), field reviewer research, consumer health promotion, education efforts, the Nursing Home Oversight Improvement Program (NHOIP), and promote enrollment in the Medicare savings programs. In addition, funds are included to pay for evaluation activities related to the expansion of premium support modeling capabilities and support contract services to price drug benefit proposals.

Training (\$3.2 million)

CMS has embarked on a 5-year plan to hire the right people at the right time for the right position to address the inevitable personnel losses due to projected retirements. The emphasis of this program will be recruitment and the comprehensive training of new hires. CMS projects that 44 percent of those eligible to retire during the time period of FY 2004 through FY 2009 will choose to do so. Full funding of the FY 2004 training budget will accommodate a training schedule for the replacement of employees

PROGRAM MANAGEMENT

and maintain the agency's ability to accomplish its mission. Training will also serve to reduce the priority skill gap, which is one of CMS's GPRA goals.

Travel (\$10.2 million)

The FY 2004 budget estimate for travel is \$10.2 million to fund a number of programmatic travel requirements, including survey and certification activities, contractor oversight activities, and activities related to legislation, such as the HIPAA, BBA, and BBRA requirements. Effective implementation requires that the CMS periodically conduct on-site visits to ensure, among other things, compliance with the terms and conditions of both contracts and cooperative agreements.

Printing and Postage (\$7.5 million)

This request provides funding for the printing of brochures that assist beneficiaries in selecting health care plans; Medicare lock-in notices, which inform beneficiaries of their initial enrollment in managed care programs; various Medicare and Medicaid program guides; *Federal Register* and *Congressional Record* materials; and other printed forms and manuals. Postage expenses to fund the disbursement of the above-mentioned material and other correspondence are also included. The postage increase of \$1.2 million is due to a change in postal policy to reclassify third-class Medicare mailings to first-class and the 3-cent increase for first-class mailings.

Medicare Appeals Process BIPA Section 522 (\$3.0 million)

CMS requests \$3.0 million to begin funding a national and a local Medicare coverage appeals process. These funds will be used to begin implementing the national coverage decision (NCD) and the local coverage decision (LCD) appeals process.

HIGLAS (\$3.7 million)

The \$3.7 million request for HIGLAS will support the CMS's administrative accounting functions. HIGLAS is a part of the Department-wide Unified Financial Management System (UFMS). The Department will have one financial management system for the CMS and Medicare contractors. Compared to multiple systems, the UFMS will reduce costs, mitigate security risks, and provide timely and accurate information for management purposes. With the unified system, CMS and the rest of the Department will have uniform business rules, data standards, and accounting policies and procedures for a more efficient implementation as administrative support functions are incorporated.

PROGRAM MANAGEMENT

HIPAA Security Rule (\$1.4 million)

This request includes \$1.4 million to begin implementing the HIPAA security rule. These funds will be used to ensure that HIPAA updates are processed in a secure environment.

Implementation of Recent Legislation and New Activities

CMS has included almost \$29.0 million in our FY 2004 Federal Administration request, above, to support BBA, the Nursing Home Oversight Improvement Program, New Freedom Initiative, SCHIP, and HIPAA enforcement. Specific activities are described in more detail below:

Balanced Budget Act

Funding will support the CMS's continuing efforts to implement the remaining provisions of the BBA. This includes funds for FTEs, overtime, contracts, printing, travel, and training necessary for on-going BBA activities.

Nursing Home Oversight Improvement Program

This funding will primarily support 35 FTEs required to oversee State activities, to provide additional assistance to State inspectors in nursing homes, and to respond to provider and consumer inquiries. CMS's request provides funds required for on-site visits to ensure State surveyors are in compliance with the Federal survey process and contractual agreements.

New Freedom Initiative

This funding will be used to promote integration of Americans with disabilities into the workforce through swift implementation of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) and to promote full access to community life through swift implementation of the *Olmstead* Supreme Court decision.

State Children's Health Insurance Program

This funding will support the continuation of the SCHIP administration for the national outreach program, targeted assistance, travel, and printing. In order to effectively and efficiently run this program, personnel are needed to review and approve State plans and amendments, monitor and evaluate the program to ensure compliance with Title XXI, receive and analyze SCHIP quarterly and annual financial reports, compile statistical information, and develop program guidance.

PROGRAM MANAGEMENT

APPROPRIATIONS HISTORY:

The table below displays Federal Administration funding levels for the past 5 years.

**Federal Administration
Appropriations History**

Fiscal Year	Funding Level	FTE Target
1999	\$455,017,000	4,268
2000	\$485,866,000	4,446
2001	\$504,704,000	4,501
2002	\$530,485,000	4,552
2003 P.B.	\$587,199,000	4,581

PROGRAM MANAGEMENT

Medicare Survey and Certification Program

Authorizing Legislation - Social Security Act, title XVIII, section 1864.

Medicare Survey and Certification Summary Table

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
Medicare Survey and Certification	\$222,118,000	\$228,790,000	\$228,955,000	+\$165,000
Support Contracts	34,279,000	18,857,000	18,692,000	-165,000
Total, Appropriation/B.A.	\$256,397,000	\$247,647,000	\$247,647,000	---
Rescissions:				
P.L. 107-116	-2,000,000			
P.L. 107-206	-1,312,000			
Net Appropriation/B.A.	\$253,085,000	\$247,647,000	\$247,647,000	---

PURPOSE AND METHOD OF OPERATIONS

CMS's FY 2004 budget request for Medicare Survey and Certification is \$247,647,000. This includes funding for surveys and the associated State costs, and contracts to support the program.

The Federal government has a responsibility to ensure that its expenditures are prudent and to protect the health and well-being of one of the Nation's most vulnerable populations. In order to secure quality care for the elderly, CMS requires that all facilities seeking participation in Medicare and Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. This includes long-term care facilities, home health agencies, hospitals, and other non-long-term care facilities.

CMS contracts with 51 State survey agencies to inspect providers and determine their compliance with specific Federal health, safety, and quality standards. There are a total of approximately 6,000 State surveyors. Staff from CMS's central and regional offices provide training to State surveyors and monitor the consistency and quality of State surveys.

Unfortunately, in 2002, 85 percent of nursing home facilities were cited for health deficiencies. The average number of deficiencies per facility was approximately 6 in

PROGRAM MANAGEMENT

2002. This data demonstrates the profound importance of regular, comprehensive inspections of health care facilities.

From FY 1993 to FY 2001, the number of total facilities participating in Medicare and Medicaid grew by 51 percent from just over 29,700 to approximately 44,700. Despite this growth in the number of facilities and the number of initial, recertification, and complaint surveys necessary, the Medicare Survey and Certification budget was relatively flat from FY 1992 to FY 1998. In FY 1992, the Survey and Certification budget was \$149.4 million; in FY 1998, it was \$154 million. This eventually led to concerns that the budget was not keeping pace with program needs and was putting beneficiaries in potential danger. Therefore, the subsequent three years included substantial increases to the budget.

Fiscal Year	Appropriation
1999	\$175,000,000
2000	\$209,674,000
2001	\$242,147,000
2002	\$253,085,000
2003 P. B.	\$247,647,000

EVALUATING THE PERFORMANCE OF STATE SURVEY AGENCIES

The manner in which CMS is evaluating the performance of State Survey Agencies (SSA) is undergoing considerable change. The following describes some of the changes that have occurred in the manner in which CMS evaluates the States' management of the certification program.

- a) **State Performance Standards** - The first formal assessment of the SSA using revised State performance standards has been completed. Categories of assessment include cost reporting; complaint management; accurate, timely data entry into the Online Survey Certification and Report (OSCAR) system; and management of the survey schedule. FY 2001 was a pilot year for SSA's using State performance standards. SSA's will be formally evaluated each year utilizing these principles.
- b) **Federal Observation and Support Survey (FOSS)** - A significantly revised FOSS process was implemented in FY 2002. The FOSS process established a uniform evaluation and scoring process that is used by Federal surveyors to conduct on-site evaluations of State survey teams conducting certification surveys. A report is generated identifying the findings of the FOSS and becomes one component of the CMS evaluation of SSA performance.
- c) **Comparative Surveys** - One type of Federal monitoring survey (FMS) is called a comparative survey. Comparative surveys utilize Federal surveyors who conduct a survey of the same facility within 60 days of the State survey. A comparative survey is very labor intensive, and as a result, the number of comparative surveys is limited. CMS is seeking a contractor to conduct some

PROGRAM MANAGEMENT

of the comparative surveys of nursing homes. This will permit CMS to significantly increase the number of comparative surveys conducted each fiscal year.

- d) **Data Analysis** - CMS is enhancing its capacity to analyze information and generate reports that would be available to regional offices (RO) to support their evaluation of SSA performance. This increased support to the regional office is expected to more quickly and consistently identify areas in need of review by the RO.

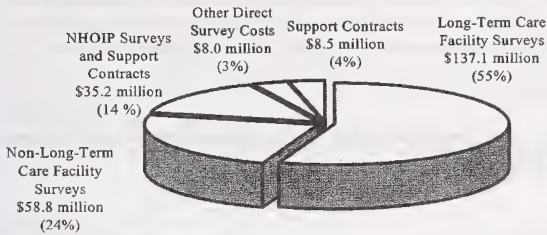
Evaluation of SSA performance is becoming more thorough and systematic and will result in the identification of areas requiring attention by the survey agency. Corrective action is expected to be taken by the SSA and monitored by the RO. Actual changes in management practices, which might include replacing poor performing State survey teams, is the responsibility of the SSA. CMS is responsible for monitoring the SSA to assess whether actions taken to address program deficiencies acceptably correct the problem.

RATIONALE FOR THE BUDGET REQUEST

This request explains the funding necessary to administer the Medicare Survey and Certification program in FY 2004. The costs to administer Medicaid Survey and Certification activities are shown in the Other Accounts tab of this justification. The FY 2004 Medicare Survey and Certification program request of \$247.6 million is separated into two main categories: direct surveys and support contracts. The majority of the budget request, 92 percent, is allocated to direct survey costs. The remaining 8 percent is for support contracts. The pie chart on the following page breaks down the program request into further detail to show direct survey costs for long-term care and non-long-term care facilities, the Nursing Home Oversight Improvement Program (NHOIP), other direct survey costs, and support contracts.

PROGRAM MANAGEMENT

Medicare Survey and Certification FY 2004 Request



DIRECT SURVEY COSTS - \$228.9 million

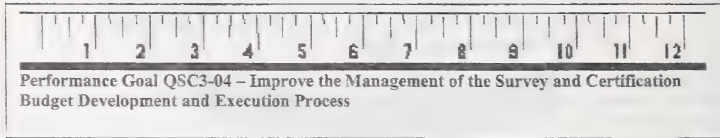
Direct survey costs represent the funding given directly to the States to perform surveys and complaint visits and to support the associated program costs. As shown below, the direct survey budget includes resources to survey all provider types, with the majority of the request funding long-term care facility surveys.

Direct Survey Costs (dollars in millions)

Provider Type	FY 2004
Skilled Nursing Facility (SNF)	\$8.2
SNF/NF (dually-certified)	128.9
Home Health Agencies	28.0
Accredited Hospitals	5.5
Non-Accredited Hospitals	7.6
ESRD Facilities	8.0
Hospices	4.0
Outpatient Physical Therapy	1.4
Outpatient Rehabilitation	0.3
Portable X-Rays	0.2
Rural Health Clinics	1.3
Ambulatory Surgical Centers	2.5
NHOIP	25.0
Other Direct Survey Costs	8.0
Total, Direct Surveys	\$228.9

PROGRAM MANAGEMENT

CMS monitors the consistency, efficiency, and quality of State surveys. The CMS Annual Performance Plan includes a survey and certification performance goal to encourage State efficiency and effectiveness in conducting surveys by incorporating a more price-based budget methodology into the budget formulation and execution process. During FY 2004, CMS will continue efforts to reduce the State variation in survey times by implementing national standards and performance measures.



CMS's FY 2004 request will allow for inspections of long-term care facilities and home health agencies at the legislatively mandated frequencies, the same level proposed in the FY 2003 President's budget. For example, the FY 2004 Statewide average interval between standard surveys will not exceed 12 months for nursing homes, and will not exceed 36 months for home health agencies, in accordance with statutory requirements. For the remaining facility types, CMS will maintain the FY 2003 recertification levels. As shown on the following page, CMS expects to complete a total of more than 23,000 inspections. In addition, CMS estimates almost 48,000 visits in response to complaints.

Recertification Level Comparison

Type of Facility	Recertification Level FY 2002	Recertification Level FY 2003	Recertification Level FY 2004
Long-Term Care Facilities	Every Year	Every Year	Every Year
Home Health Agencies	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	5% Per Year	1% Per Year	1% Per Year
Non-Accredited Hospitals	Every 3 Years	Every 3 Years	Every 3 Years
ESRD Facilities	Every 3 Years	Every 3 Years	Every 3 Years
Hospices	Every 6 Years	Every 6 Years	Every 6 Years
Outpatient Physical Therapy	Every 6 Years	Every 6 Years	Every 6 Years
Outpatient Rehabilitation	Every 6 Years	Every 6 Years	Every 6 Years
Portable X-Rays	Every 6 Years	Every 6 Years	Every 6 Years
Rural Health Clinics	Every 6 Years	Every 6 Years	Every 6 Years
Ambulatory Surgical Centers	Every 6 Years	Every 6 Years	Every 6 Years

PROGRAM MANAGEMENT

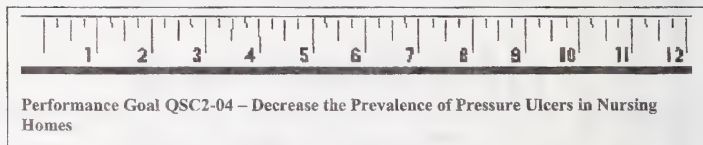
Surveys and Complaint Visits
FY 2003 vs. FY 2004

	FY 2003 President's Budget				FY 2004 Estimate			
Type of Facility	Total Recert Surveys	Total Initial Surveys	Total Complaint Visits	Total Surveys and Visits	Total Recert Surveys	Total Initial Surveys	Total Complaint Visits	Total Surveys and Visits
Skilled Nursing Facility (SNF)	1,010	51	771	1,832	1,046	33	858	1,937
SNF/NF (dually-certified)	13,734	306	39,153	53,193	13,842	251	43,727	57,820
Home Health Agencies	2,351	165	1,898	4,414	2,291	201	1,589	4,081
Accredited Hospitals	43	59	1,188	1,290	45	67	1,048	1,160
Non-accredited Hospitals	563	127	326	1,016	596	102	144	842
ESRD Facilities	1,441	267	307	2,015	1,477	245	263	1,985
Hospices	373	106	246	725	390	91	259	740
Outpatient Physical Therapy	491	278	14	783	502	231	12	745
Outpatient Rehabilitation	82	96	4	182	90	83	6	179
Portable X-Rays	116	32	2	150	111	29	0	140
Rural Health Clinics	522	252	24	798	545	208	26	779
Ambulatory Surgery Centers	605	267	33	905	656	279	0	935
Total	21,331	2,006	43,966	67,303	21,591	1,820	47,932	71,343

PROGRAM MANAGEMENT

In FY 2004, the direct survey cost estimate includes \$25.0 million for Nursing Home Oversight Improvement Program direct survey costs. CMS continues to monitor the progress in areas targeted by the Nursing Home Oversight Improvement Program. CMS will continue activities already initiated to ensure that Medicare beneficiaries in nursing homes receive quality care in a safe environment. These include the following:

- investigating, processing, and reporting complaints which allege actual harm within 10 days (\$10.1 million);
- imposing immediate sanctions for nursing homes found to have care deficiencies that involve actual patient harm on any survey (\$6.3 million);
- developing a systematic, more comprehensive survey process to more effectively detect critical quality of care problems (\$7.3 million);
- staggering inspection times to include a set amount begun on weekends and evenings (\$0.6 million); and
- focusing surveys on two repeat offenders with serious violations per State (\$0.7) million.



The FY 2004 direct survey cost estimate also includes \$8.0 million for several continuing activities:

- Minimum Data Set (MDS) State program costs, including system maintenance and ongoing collection and housing of data used in the development and testing of program improvement projects (\$4.0 million);
- Outcome and Assessment Information Set (OASIS) State program costs, including providing training to all home health agency providers on the OASIS, operating the system, running reports, and providing technical support (\$3.0 million); and
- printing, transcripts, and travel costs (\$1.0 million).

PROGRAM MANAGEMENT

SUPPORT CONTRACTS - \$18.7 million

Support contracts, managed internally by CMS, constitute \$8.5 million of the FY 2004 request. Critical Survey and Certification support contracts include, but are not limited to, the following: surveyor training; logistical support services; maintenance and enhancement of the OSCAR data system; the Surveyor Minimum Qualifications Test (SMQT); as well as other efforts to ensure national program oversight and consistency.

In addition to the internally managed support contracts, CMS also has NHOIP support contracts which total \$10.2 million. A few activities that this funding level covers include comparative surveys for nursing homes, expert testimony, nursing home staffing data, contractor survey development, and the review of abuse prevention efforts. The total support contracts funding request for FY 2004 is \$18.7 million.

PROGRAM MANAGEMENT

SUMMARY OF THE NURSING HOME OVERSIGHT IMPROVEMENT PROGRAM

CMS's FY 2004 budget includes \$92.4 million dedicated to the Nursing Home Oversight Improvement Program (NHOIP). CMS has made significant strides in the areas targeted by this program, and is committed to continuing to work with residents and their families, advocacy groups, providers, States, and Congress to ensure that residents receive the quality care and protection they deserve. This budget reflects CMS's continued commitment. As discussed below, there are several funding sources for this program.

Funding Source, NHOIP	FY 2004 Estimate (in millions)
Discretionary:	
Medicare Survey and Certification	\$35.2
Federal Administration	4.8
Subtotal, Discretionary	\$40.0
Mandatory:	
Medicaid Survey and Certification	\$44.0
Quality Improvement Organization Support Contracts	8.4
Subtotal, Mandatory	\$52.4
Total, CMS	\$92.4

SURVEY AND CERTIFICATION - \$35.2 million

Please refer to the Medicare Survey and Certification Program section.

FEDERAL ADMINISTRATION - \$4.8 million

As shown below, the NHOIP request includes Federal oversight activities and other associated costs.

Federal Oversight - \$3.4 million

CMS will maintain 35 FTEs to continue the following activities:

- Process sanction notices and respond to litigation and appeals;
- Provide additional training and other assistance to inspectors in States, ensure that proper Federal protocols are being followed, and enhance national uniformity of oversight in the protection of residents;

PROGRAM MANAGEMENT

- Monitor and update information about abuse prevention efforts in nursing homes, and respond to provider and consumer inquiries;
- Develop State sanction options that may be imposed, including termination of Federal nursing home survey funding for those States that fail to comply with Federal survey protocols or fail to improve inadequate survey systems; and
- Ensure that State surveyors enforce existing policy to sanction nursing homes with serious violations, and that sanctions cannot be lifted until after an onsite visit has verified compliance.

Other - \$1.4 million

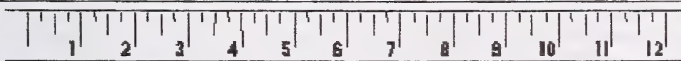
The Federal Administration account also includes funding for travel, contracts, supplies, printing, and equipment associated with the NHOIP.

MANDATORY**Medicaid State Survey Costs - \$44.0 million**

State Medicaid programs will share in the direct survey costs and complaint visit costs associated with the NHOIP for dually certified nursing facilities and Medicaid only nursing homes.

Quality Improvement Organization (QIO) Support Contracts - \$8.45 million

The QIO 7th Scope of Work includes \$8.4 million in FY 2004 for support contracts supporting the NHOIP, which includes \$4.0 million for Minimum Data Set (MDS), \$1.8 million for Outcome and Assessment Information Set (OASIS) accuracy review contracts, \$2.0 million for promotion, quality, and continuing research in nursing homes, \$500,000 for website support for nursing home compare, and \$150,000 for measurement refinement in nursing homes.



Performance Goal QSC1-04 – Decrease the Prevalence of Restraints in Nursing Homes

PROGRAM MANAGEMENT

Research, Demonstration and Evaluation

Authorizing Legislation - Social Security Act, Sections 1110, 1115, 1875 and 1881(a); Social Security Amendments of 1967, Section 402; Social Security Amendments of 1972, Section 222.

Research, Demonstration and Evaluation Summary Table

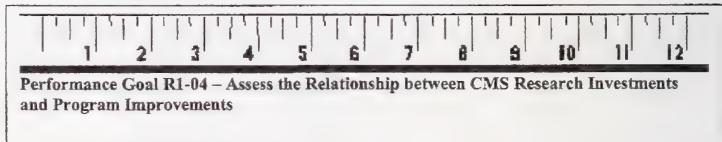
	2002 Actual	2003 President's Budget	2004 Estimate	Increase Or Decrease
Appropriation/B.A.	\$118,201,000	\$28,400,000	\$63,400,000	+\$35,000,000
Rescission:				
P.L. 107-116	-1,000,000			
Net Appropriation/B.A.	\$117,201,000	\$28,400,000	\$63,400,000	+\$35,000,000

PURPOSE AND METHOD OF OPERATIONS

The FY 2004 estimate for funding CMS's Research, Demonstration and Evaluation (RD&E) activity is \$63.4 million. The FY 2004 request reflects an increase of \$35 million from the FY 2003 President's budget. The RD&E program supports CMS's key role as a beneficiary-centered purchaser of high-quality health care at a reasonable cost.

RATIONALE FOR THE BUDGET REQUEST

The FY 2004 RD&E budget will continue to support research and demonstrations directed at helping to chart the course for the future of our programs. CMS has participated actively in the Department's Research Coordination Council (RCC) to ensure that the agency's FY 2004 planned research, demonstration, and evaluation (RD&E) activities align with the President's and Secretary's priority areas; identify opportunities for increased collaboration with other DHHS Agencies; avoid overlapping areas of focus across agencies; and fill potential gaps in research efforts. For example, the RCC identified a need for increased CMS resources to support the production of Medicaid and Medicare databases to support DHHS research priorities, as well as a need to increase coordination of grant programs for minority researchers. The narrative and table below categorizes our proposed research based on the Department's research themes for FY 2004.



PROGRAM MANAGEMENT

FY 2004 RD&E Funding by DHHS Research Priority
(dollars in thousands)

Research Priority	FY 2004 Budget Request (\$ in 000s)
V. Protecting and Empowering Specific Populations A. New Freedom Initiative—Enable People with Disabilities to Live Self-Sufficiently and with Dignity BA.....	\$43,000
V. Protecting and Empowering Specific Populations B. Medicare Modernization BA.....	
VI. Helping the Uninsured and Increasing Access to Health Insurance A. Medicaid & SCHIP BA.....	
IX. Understanding Health Differences and Disparities—Closing the Gaps A. Health Disparities Research BA.....	
X. Preventing Disease, Illness and Injury A. Prevention Research—General BA.....	
XI. Agency-Specific Priorities Topic 1 BA.....	\$7,000
RD&E Funding by Departmental Themes	\$50,000
Medicare Current Beneficiary Survey	\$13,400
Total RD&E Request	\$63,400

Theme V. Protecting and Empowering Specific Populations

These R&D efforts are intended to provide information needed for modernization of our programs, including Medicare reform efforts in both managed care and fee-for-service, and Medicaid reforms that increase State flexibility in providing coverage to the uninsured and ongoing efforts to improve services provided to the disabled. Our R&D under this theme also supports monitoring and evaluation activities to track how well Medicare meets the needs of specific groups of beneficiaries, including vulnerable populations and to examine specific policy issues within CMS's programs. For example, as Medicare pursues new managed care options, beneficiary satisfaction, quality of care, and cost-effectiveness of these new approaches must be assessed.

PROGRAM MANAGEMENT

New Freedom Initiative– \$3 million

In support of the New Freedom Initiative, CMS will continue a national demonstration designed to address workforce shortages of community service direct care workers. The demonstration will test the extent to which workforce shortages and instability might be addressed through better coordination with Temporary Assistance for Needy Families and the availability of vouchers for worker health insurance or for tuition/day care credits. Participating States would be expected to develop options for workers to purchase affordable group health coverage through the State health insurance system or similar organized insurance group.

Real Choice System Change Grants – \$40 million

The Budget proposes to continue funding for Real Choice System Change Grants. The grants are intended to assist States to design and implement enduring improvements to community based support systems that enable people with disabilities and long-term illnesses to live and participate in community life. These systematic changes will be designed to enable children and adults of any age with a disability or long term illness to (1) live in the most integrated community setting, (2) exercise meaningful choices about their living environment, and (3) obtain quality services in a manner as consistent as possible with community living preferences and priorities. In FY 2002, a total of \$40.0 million funded 25 new Real Choice Systems Change Grants and 5 supplemental Real Choice System Change Grants.

Theme VI. Helping the Uninsured and Increasing Access to Health Insurance

CMS will continue evaluations of SCHIP, Medicaid, and demonstrations mandated by the Ticket to Work and Work Incentives and Improvement Act of 1999. The Ticket to Work statute requires a report to Congress on the impact of the Medicaid buy-in programs and the utilization of the Medicaid Infrastructure Grants. In FY 2004, the RD&E budget will support efforts to gather and analyze the outcomes and lessons learned from the Medicaid buy-in programs. Currently, 17 States are operating Medicaid buy-in programs and 38 States are receiving grant funds for these efforts.

Theme IX. Understanding Health Differences and Disparities

Research is needed to identify existing initiatives that have helped reduce disparities and develop intervention strategies designed to eliminate disparities that impact the health status among women, racial, ethnic, and other vulnerable populations (e.g., African-Americans, Hispanics, Asians and Pacific Islanders, and American Indians/Alaska Natives). Examples of areas of intervention include: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and child and adult immunization. Current research is being designed to improve understanding of the impact of these utilization differences on the health of the population.

PROGRAM MANAGEMENT

Theme X. Preventing Disease, Illness, and Injury

Several new payment and service delivery models have been identified as important components of a modernized Medicare program including care coordination and disease management services. These components will be explored through a combination of testing new fee-for-service care management approaches for selected populations with conditions such as diabetes, coronary disease, and congestive heart failure.

Theme XI. Agency Specific Priorities

CMS's research budget supports a variety of activities to increase the efficiency of our research and demonstration program and meet the cross-cutting research needs of CMS and the wider health research community. CMS's RD&E budget also supports funding for the Medicare Current Beneficiary Survey (MCBS). MCBS is the only comprehensive source of information on the health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of the entire spectrum of Medicare beneficiaries. MCBS is a powerful tool for evaluating our programs, as well as a key source of data for policy research on the Medicare population.

MANDATED RESEARCH INITIATIVES

The Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) mandate many demonstrations and evaluations, studies, reports to Congress, and the implementation of several prospective payment systems. The RD&E budget will support our continuing efforts to implement the remaining provisions of BBA, BBRA, and BIPA. The following table displays specific needs for BBA, BBRA, and BIPA:

Legislation	Mandated RD&E Projects
Balanced Budget Act	➤ Coordinated care demonstration and evaluation ➤ Prospective Payment System (PPS) for inpatient rehab ➤ Home Health Agency PPS ➤ Evaluation of PACE
Balanced Budget Refinement Act	➤ Develop PPS for inpatient psychiatric hospital services ➤ Conduct study of impact of PPS for inpatient rehabilitation ➤ End-Stage Renal Disease (ESRD) PPS implementation
Benefits Improvement and Protection Act	➤ Disease management for severely chronically ill Medicare beneficiaries demonstration and evaluation ➤ Cancer prevention and treatment for ethnic and racial minorities demonstration and evaluation ➤ Assessments/refinements for SNF PPS ➤ Physician group practice demonstration and evaluation

PROGRAM MANAGEMENT

APPROPRIATION HISTORY:

The table below displays Research funding for the past 5 years.

**Research, Demonstration and Evaluation
Appropriation History**

Fiscal Year	Funding Level
1999	\$50,000,000
2000	\$61,786,000
2001	\$138,311,000
2002	\$117,201,000
2003 P.B.	\$28,400,000

PROGRAM MANAGEMENT

CMS Revitalization Plan

Budget Estimates

As described in the Executive Summary portion of this document, CMS is requesting a new, multi-year investment fund, beginning with \$65 million in two-year money to be appropriated in FY 2004. In the first year, the CMS revitalization plan will focus on systems-related activities.

CMS Revitalization Plan Summary Table

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
Systems Security Risk Mitigation	N/A	N/A	\$34,000,000	\$34,000,000
Modernize Fee-for-Service (FFS) Claims Processing Systems	N/A	N/A	\$17,800,000	\$17,800,000
Modern Data Warehousing Environment	N/A	N/A	\$11,200,000	\$11,200,000
E-gov and Aging Infrastructure	N/A	N/A	\$2,000,000	\$2,000,000
Total, CMS Revitalization Plan	N/A	N/A	\$65,000,000	\$65,000,000

RATIONALE FOR THE BUDGET REQUEST

CMS's systems infrastructure was not designed to keep pace with recent changes in the program or to handle today's massive claims volume, much less the increase in claims volume that will come as today's "baby boomers" become eligible for Medicare. Over the past few years, CMS has taken steps toward revitalizing its operations, such as reducing the number of standard fee-for-service claims processing systems. However, a significant investment is needed if CMS and its partners are to continue to meet the demands of the Medicare program and provide quality service to its beneficiaries.

PROGRAM MANAGEMENT

INFORMATION TECHNOLOGY

CMS faces four major IT challenges over the next several years:

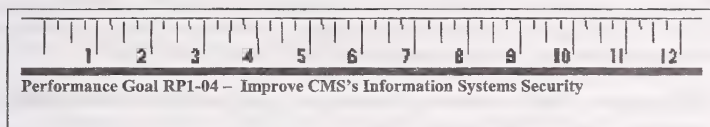
1. Securing critical and sensitive data at CMS's Medicare contractors to prevent unauthorized access to and use of beneficiary and financial data.
2. Modernizing CMS's Medicare fee-for-service claims processing environment to effectively support CMS's transaction processing responsibilities under Medicare.
3. Modernizing CMS's database environment to effectively support Medicare transaction processing, program integrity, quality of care, and program administration responsibilities to effectively manage both Medicare and Medicaid.
4. Investing in CMS's aged infrastructure to support e-gov activities and to prevent disruptions in services from an aging infrastructure.

Highlights of the Budget Estimates**Systems Security Risk Mitigation**

Since 2000, CMS has been making significant progress in improving information systems security at the Medicare contractor sites. This progress has increased the safeguards in place to protect the health care information processed and generated by the Medicare contractors through the Medicare claims process. These safeguards are essential to ensuring the confidentiality and privacy of the health care information of Medicare beneficiaries, as required by both Federal law and regulation.

Despite this progress and CMS's best efforts, recent self-assessments as well as audits initiated by the Office of the Inspector General have revealed that the Medicare contractors fall substantially short of meeting a set of core security requirements based on various Federal laws and regulations. In FY 2001, CMS conducted a comprehensive security assessment at its Medicare contractors to determine compliance with NIST, GAO, OMB, and legislative requirements and to assess security risks and vulnerabilities. That assessment identified numerous systems control weaknesses. These weaknesses were documented in the HHS *Inspector General's Report on the HHS Consolidated/Combined Financial Statements for FY 2001*, with specific problems related to access controls and systems software issues. As noted during a hearing of the House Energy and Commerce Committee in 2001, CMS's systems security must be held to a higher standard than other government agencies because of the volume and sensitivity of personally identifiable data.

PROGRAM MANAGEMENT



CMS's FY 2004 President's Budget request includes \$34 million to enable CMS and Medicare contractors to address the most serious known security risks and vulnerabilities, develop systems security plans, and implement a robust, ongoing security program.

Modernize Fee-for-Service Claims Processing Systems

CMS's fee-for-service (FFS) systems face major challenges as CMS fulfills its responsibility to process and pay claims rapidly and, more importantly, to make the correct payment determination while managing immense volumes of data. The Medicare claims processing systems support the annual processing of 1 billion Medicare FFS claims, representing over \$250 billion in program payments. The volume of transactions is increasing and the process is becoming more complex. Moreover, Medicare claims processing systems are a major source of data for national healthcare research; fraud, waste, and abuse prevention programs; and the evaluation of demonstrations, clinical trials, and other program development initiatives.

CMS's FY 2004 budget includes \$17.8 million to initiate a Medicare data center contracting strategy, begin a redesign of the Common Working File (CWF) and Medicare claims processing systems, and begin modernization of the Medicare enrollment database (EDB). These investments will enable CMS and our partners to meet increasing business demands, improve the management of Medicare claims processing, and provide improved reliability.

Modern Data Warehousing Environment

While continuing its operational and transactional (e.g., enrollment, payment) responsibilities under Medicare, CMS has been uniquely entrusted with massive oversight and stewardship responsibilities for data regarding its programs and beneficiaries. Diverse activities including transaction processing (e.g., claims review and payment), beneficiary education and communication, program integrity, policy analysis and decision-making in a complex program environment such as Medicare and Medicaid, all require appropriate levels of investments in IT infrastructure to support data quality and maintenance, transaction processing against central data warehouses, and data analysis and information dissemination.

PROGRAM MANAGEMENT

The current (legacy) data environment, which supports CMS business operations, has become increasingly difficult and costly to support. Furthermore, these legacy databases do not satisfy technical and data management requirements for the future.

Modernization of CMS's database environment is required to meet the future needs of the agency. The FY 2004 President's budget includes \$11.2 million to support implementation of an integrated, relational data warehouse environment that supports CMS transaction and information processing needs under Medicare and Medicaid. Supported activities include conversion of remaining legacy systems from M204 to DB2 and development of the architecture for "data marts" to provide mission-critical information and decision support tools for Medicare and Medicaid.

E-gov and Aging Infrastructure

CMS's internal systems (infrastructure) reflect aging technology. Key technology components that support CMS's day-to-day operations must be modernized to avoid service disruptions. CMS's e-mail system and document management systems, both of which are key not only to internal business operations but also our responsiveness to the public and Congress, will be improved as a result of this initiative. Investments in authentication and encryption methods/tools, role-based access controls, electronic signatures, and other security investments are necessary to support a robust e-gov/e-commerce environment.

The budget includes \$2 million to support investments in e-gov security infrastructure and related infrastructure modernization. E-gov investments include development of authentication and encryption architecture, internal pilots of electronic signatures, and penetration testing of security infrastructure. Modernization activities planned for FY 2004 include identification of a preferred technology solution and development of an implementation strategy.

Section III Contents

OTHER APPROPRIATED ACCOUNTS

Medicaid Grants to States	III-1
Payments to the Health Care Trust Funds.....	III-23
HMO Loan and Loan Guarantee Fund	III-33

OTHER APPROPRIATED ACCOUNTS

Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, \$124,892,197,000 to remain available until expended.

For making, after May 31, 2004, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2004 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or in the case of section 1928 on behalf of States under title XIX for the first quarter of fiscal year 2005, \$58,416,275,000 to remain available until expended.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

OTHER APPROPRIATED ACCOUNTS

MEDICAID

Language Analysis

Language Provision

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, \$124,892,197,000 to remain available until expended.

For making, after May 31, 2004, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2004 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

Explanation

This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the advance appropriation of \$51.9 billion provided for the first quarter of FY 2004 under the anticipated FY 2003 Department of Health, and Human Services Appropriations Act. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers.

This section provides indefinite authority only for payments to States in the last quarter of fiscal year 2004 to meet unanticipated costs. This language does not provide this authority to the Vaccines for Children program for payments on behalf of States during this time period.

OTHER APPROPRIATED ACCOUNTS

Language Analysis

Language Provision

For making payments to States or in the case of section 1928 on behalf of States under title XIX for the first quarter of fiscal year 2005, \$58,416,275,000 to remain available until expended.

Payments under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

Explanation

This section provides an advanced appropriation for the first quarter of fiscal year 2005 to ensure continuity of funding for the Medicaid program in the event a regular appropriation for fiscal year 2005 is not enacted by October 1, 2004. It makes clear that the language provides budget authority to the Vaccines for Children program during the first quarter of a fiscal year.

This section makes clear that funds are available with respect to State plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

OTHER APPROPRIATED ACCOUNTS

Authorizing Legislation - Social Security Act, title XIX, Section 1901.

Budget Authority By Activity
(dollars in thousands)

Medicaid Appropriation	FY 2002 Actual	FY 2003 President's Budget 1/	FY 2004 Estimate	Increase or Decrease
Medical Assistance Payments (gross)	\$142,585,192	\$152,534,837	\$166,706,067	\$14,171,230
Vaccines for Children	982,667	1,056,185	980,196	-75,989
State and Local Administration, Survey and Certification, and Fraud Control Units	8,075,849	8,901,982	9,067,320	165,338
Obligations (gross)	151,643,708	162,493,004	176,753,583	14,260,579
Unobligated Balance, Start of Year	-110,021	-6,893	0	6,893
Unobligated Balance, End of Year	6,893	0	0	0
Recoveries of Prior Year Obligations	-4,198,147	0	0	0
Appropriation Budget Authority (gross)	147,342,433	162,486,111	176,753,583	14,267,472
Offsetting Collections	-137,917	-127,000	0	127,000
Change in Receivables	135,823	0	0	0
Total Budget Authority (net)	\$147,340,339	\$162,359,111	\$176,753,583	\$14,394,472
Indefinite Appropriation	-4,310,906	-3,666,956	0	3,666,956
Advanced Appropriation	-36,207,551	-46,601,937	-51,861,386	-5,259,449
Annual Appropriation	\$106,821,882	\$112,090,218	\$124,892,197	\$12,801,979

1/ This column reflects the current estimate for FY 2003. The total budget authority in the FY 2003 President's budget was \$158,692,155,000. The change reflects an indefinite authority appropriation request to meet unanticipated program cost increases.

I. Background of the Medicaid Program

Authorized under title XIX of the Social Security Act, Medicaid is generally a means-tested health care entitlement program financed by States and the Federal Government. The State share varies from State to State. In FY 2002, the average State share was approximately 43 percent with the remaining 57 percent provided by the Federal Government. All 50 States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam) have elected to establish Medicaid programs. States have considerable flexibility in structuring their Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. As a result, Medicaid programs vary widely from State to State. Medicaid law defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandatory in all States and those that may be covered at a State's option. In general, most individuals who are eligible for cash assistance under the Supplemental Security Income (SSI) program, or who meet the income and resource requirements of the Aid to Families with Dependent Children (AFDC) cash assistance program as it existed in July 1996, must be covered under the State Medicaid program. Other Federally-mandated coverage groups include low-income pregnant women and children and qualified Medicare beneficiaries who meet certain income and/or eligibility criteria. At their option, States may expand these mandatory groups or cover additional populations including the medically needy. Medically needy persons are those who do not meet the income or resource standards of the other categorical eligibility groups, but incur large medical expenses such that when subtracted from their income, puts them within eligibility standards.

Medicaid covers a broad range of services to meet the health needs of beneficiaries. Federally-mandated services for categorically-eligible Medicaid beneficiaries include hospital inpatient and outpatient services, comprehensive health screening, diagnostic and treatment services to children, home health care, laboratory and x-ray services, physician services, and nursing home care for individuals age 21 or older. Commonly offered optional services for both categorically and medically-needy populations include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, and services in intermediate care facilities.

Medicaid payments are made directly by the States to the health care provider or health plan for services rendered to beneficiaries. Providers must accept the State's payment as full recompense. By law, Medicaid is the payer of last resort. If any other party, including Medicare, is legally liable for services provided to a Medicaid beneficiary, that party must first meet its financial obligation before Medicaid payment is made.

OTHER APPROPRIATED ACCOUNTS

II. Medicaid Managed Care

One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery method. Prior to 1982, 99 percent of Medicaid recipients received coverage through fee-for-service arrangements. With the passage of the Omnibus Budget Reconciliation Act of 1981 and the Balanced Budget Act of 1997, there has been a vast increase in the number of Medicaid recipients enrolled in a managed care organization. As of December 31, 2001, more than half of all Medicaid beneficiaries (approximately 22 million) in 48 States and the District of Columbia were enrolled in some type of managed care delivery system. States continue to experiment with various managed care approaches in their efforts to reduce unnecessary utilization, contain costs, improve access to services, and achieve greater continuity of care.

Prior to the passage of the Balanced Budget Act of 1997, States primarily used section 1915(b) or freedom of choice waivers and section 1115 research and demonstration waivers to develop innovative managed care delivery systems. Section 1915(b) waivers are used to enroll beneficiaries in mandatory managed care programs; provide additional services via savings produced by managed care; create a “carve out” delivery system for specialty care, e.g., behavioral health; and/or create programs that are not available statewide. Section 1115 demonstrations allow States to test programs that vary in size from small-scale pilot projects to statewide demonstrations, test new benefits, financing mechanisms, or significantly restructure State Medicaid programs.

The Balanced Budget Act of 1997 increased State flexibility to allow States to mandatorily enroll certain Medicaid groups (with the exception of special needs children, Medicare beneficiaries, and Native Americans) into managed care through a State plan amendment (SPA).

As Medicaid managed care programs continue to grow, CMS remains committed to ensure that high-quality, cost-effective health care is provided to Medicaid beneficiaries. CMS’s efforts include evaluating and monitoring demonstration and waiver programs, improving information systems, providing expedited review of State proposals, and improving coordination with other HHS components providing technical assistance to States related to managed care.

III. Distribution of Medicaid Benefit Services and Growth

As displayed in the table on the following page, Medicaid medical assistance payments are projected to increase \$14.5 billion, or 9.5 percent, from the estimated \$152.9 billion in FY 2003 to \$167.4 billion in FY 2004.

Long-term care services is the largest Medicaid benefit service category. It is composed of nursing facilities and intermediate care facilities for the mentally retarded. These services are estimated to require \$34.8 billion in funding for FY 2004, representing 21.6 percent of the State benefit estimates for FY 2004. The second largest FY 2004 Medicaid category of service is health insurance payments. The States have submitted FY 2004 estimates totaling \$32.6 billion or about 20.2 percent of Medicaid benefits. The next largest categories of Medicaid services for FY 2004 are inpatient hospital services (\$21.9 billion) followed by prescribed drugs (\$17.5 billion). Together these four benefit service categories for long-term care services, health insurance payments, inpatient hospital services and prescribed drugs account for more than 60 percent of the State estimated cost of the Medicaid program for FY 2004.

According to State estimates, the fastest growing service category in the Medicaid program is prescribed drugs. States expect the prescribed drug category, which includes drug rebate offsets, to grow by \$2.2 billion, or 14.1 percent, between FY 2003 and FY 2004. The State estimate increase in prescribed drugs accounts for 14.9 percent of the total FY 2004 benefit growth.

Health insurance payments continue to be a rapidly growing service category. This category, comprised primarily of premiums paid to medical managed care plans, is projected to grow by \$2.9 billion, or 9.8 percent. The State estimate increase in health insurance payments accounts for 20.0 percent of the total FY 2004 benefit growth. Rising enrollments and shifts in how services are paid, e.g., from fee-for-service to capitated plans, explain this growth.

All other aggregated categories of service display less than 9.5 percent growth. The slowest growing service category is long-term care, which the States expect will increase only \$1.3 billion, or 3.9 percent, over FY 2003. This category includes nursing facilities and intermediate care facilities for the mentally retarded. The States expect that the impact of final rules issued in FY 2002 regarding revisions to Medicaid upper payment limit requirements will particularly retard the growth in spending on nursing facilities.

OTHER APPROPRIATED ACCOUNTS

Estimated Benefit Service Growth, FY 2003 to FY 2004
 November 2002 State-Submitted Estimates and Actuarial Adjustments
 (dollars in thousands) 1/

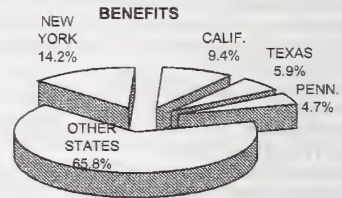
Major Service Category	Est. FY 2003	Est. FY 2004	Dollar Growth	Percent Growth	Percent Of Total Growth
Health Insurance Payments (Medicare premiums, coinsurance and deductibles, primary care case management, group and prepaid health plans, managed care organizations, and other premiums)	\$29,689,748	\$32,595,156	\$2,905,408	9.8%	20.0%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	\$15,307,355	\$17,471,237	\$2,163,882	14.1%	14.9%
Long-Term Care (Nursing facilities, intermediate care facilities for the mentally retarded)	\$33,531,539	\$34,825,988	\$1,294,449	3.9%	8.9%
Institutional Alternatives (Personal care, home health, and home and community-based care)	\$16,138,659	\$17,270,270	\$1,131,611	7.0%	7.8%
Inpatient Hospital (Regular payments -inpatient hospital and mental health facilities)	\$20,767,344	\$21,889,690	\$1,122,346	5.4%	7.7%
Physician/Practitioner/ Dental	\$7,434,640	\$8,105,580	\$670,940	9.0%	4.6%
Outpatient Hospital	\$5,723,499	\$6,259,659	\$536,160	9.4%	3.7%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT))	\$5,604,122	\$6,030,005	\$425,883	7.6%	2.9%
Disproportionate Share Hospital Payments (Adjustment payments - inpatient hospital and mental health facilities)	\$8,893,644	\$8,362,369	-\$531,275	-6.0%	-3.7%
Other (Targeted case management, hospice, all other services, and collections)	\$7,801,118	\$8,330,961	\$529,843	6.8%	3.7%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	\$150,891,668	\$161,140,915	\$10,249,247	6.8%	70.7%
Medicare Part B Transfer	\$50,000	0	-\$50,000	NA	-0.3%
Actuarial Adjustments	\$1,958,332	\$6,259,085	\$4,300,753	NA	29.7%
TOTAL	\$152,900,000	\$167,400,000	\$14,500,000	9.5%	100.0%

1/ Totals/differences may not add due to rounding.

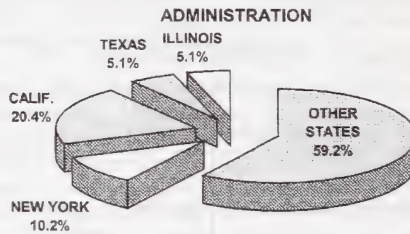
OTHER APPROPRIATED ACCOUNTS

IV. Distribution of FY 2004 Medicaid Monies By State**STATE DISTRIBUTION OF MEDICAID BENEFITS**

According to the State-submitted estimates, \$161.1 billion will be required to fund their Medicaid benefit programs during FY 2004. As displayed, four States account for \$55 billion, or 34.1 percent, of the State-submitted estimates for benefits for FY 2004. The next six States in ranking of estimated benefits are Ohio (4.3 percent), Florida (4.2 percent), North Carolina (3.3 percent), Illinois (3.2 percent), Massachusetts (2.8 percent), and Michigan (2.8 percent). These six States account for an additional 20.6 percent of total State-submitted benefit estimates. In total, these 10 States are expected to account for over 54 percent of Medicaid benefits in FY 2004.

**STATE DISTRIBUTION OF MEDICAID STATE AND LOCAL ADMINISTRATION**

The State-submitted estimates for FY 2004 State and local administration costs total \$8.3 billion. This represents about 5.2 percent of the total State-submitted estimates for Medicaid program costs for FY 2004. As displayed, four States account for \$3.4 billion or 38.9 percent of expenditures for State and local administration. The next



six States in ranking of estimated expenditures are Washington (4.1 percent), Pennsylvania (4.0 percent), Florida (3.8 percent), Ohio (3.2 percent), Michigan (3.1 percent), and Massachusetts (2.8 percent). These six States account for an additional 21.1 percent of total State and local administration expenditures.

In total, these 10 States are expected to account for about 60 percent of Medicaid expenditures for State and local administration.

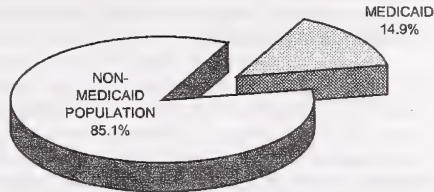
OTHER APPROPRIATED ACCOUNTS

V. Composition of the Medicaid Population

According to our projections of Medicaid enrollment in FY 2004, as shown in the pie chart, 14.9 percent, or 42.4 million, of the estimated 285.3 million U.S. residents will be enrolled in Medicaid for the equivalent of a full year during FY 2004.

The proportion of children and women in the U.S. who are enrolled in the Medicaid program is far higher. The estimated 19.6 million children served by Medicaid in FY 2004 represent more than one out of every five children in the Nation.

FY 2004 ESTIMATED MEDICAID FULL YEAR ENROLLEES COMPARED TO THE U.S. POPULATION



CMS projects that in FY 2004 non-disabled adults under age 65 and children will represent 71 percent of the Medicaid population, but account for approximately 31 percent of the Medicaid benefit outlays, excluding disproportionate share hospital (DSH) payments. In contrast, the elderly and disabled populations are estimated to make up about 29 percent of the Medicaid population, yet account for approximately 69 percent of the non-DSH benefit outlays. Medicaid is now the largest payer for long-term care for all Americans.

The following table reflects the estimated annual enrollment in number of person years receiving Federal Medical Assistance. The data are based on the 56 jurisdictions participating in the program.

Medicaid Enrollment (Person-Years in Millions)

Excludes Uninsured Individuals Receiving Medicaid Through Section 1115 Waivers

	FY 2002 Actual	FY 2003 Estimate	FY 2004 Estimate
Age 65 and Over	4.2	4.3	4.3
Disabled	7.5	7.8	7.9
Children	18.4	19.1	19.6
Adults	9.8	10.3	10.6
TOTAL	39.9	41.4	42.4

OTHER APPROPRIATED ACCOUNTS

Under current law, the estimated Federal share of Medicaid gross obligations is estimated to be \$176.8 billion in FY 2004. This represents an increase of 8.8 percent over the analogous estimated gross obligation level of \$162.5 billion for FY 2003. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 2.4 percent during this time period. The FY 2003 enrollment estimate reflects an increase of an additional 1 million recipients above the estimate of 40.4 million recipients included in the FY 2003 President's budget.

VI. Section 1115 Statewide Health Care Reform Demonstrations

States have sought section 1115 demonstrations to expand health care coverage to the low-income uninsured and test innovative approaches in health care service delivery. Currently, CMS has approved 27 statewide comprehensive health care reform demonstrations in 23 States (Arizona, Arkansas, California, Colorado, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, and Wisconsin) and the District of Columbia. CMS has also approved two substate health reform demonstrations (California and Kentucky) and 10 demonstrations specifically related to family planning (Alabama, Arkansas, California, Florida, New Mexico, Oregon, South Carolina, Virginia, Washington, and Wisconsin). Some statewide demonstrations expand health coverage to the uninsured, and others test new methods for delivering health care services. Many of the demonstrations include the Temporary Assistance for Needy Families (TANF) and related populations, and some include the elderly and the disabled. Although the demonstrations vary greatly, most employ a common overall approach: expanding the use of managed care delivery systems for the Medicaid population. By implementing managed care, States hope to provide improved access to primary care for low-income beneficiaries, along with increased access to preventive care measures and health education. Another typical approach in many demonstration States is to use managed care savings to assist in offsetting the cost of providing coverage for the uninsured.

A. Health Insurance Flexibility and Accountability (HIFA) Demonstrations

In August 2001, President Bush announced a new section 1115 initiative entitled the HIFA demonstration initiative. HIFA enables States to use Medicaid and SCHIP funds in concert with private insurance options to expand coverage to low-income uninsured individuals, with a focus on those with

OTHER APPROPRIATED ACCOUNTS

income at or below 200 percent of the Federal poverty level (FPL). The primary features of the HIFA initiatives are as follows:

- Encourages States to develop comprehensive health insurance coverage approaches that utilize available Medicaid and SCHIP funding to address insurance coverage for individuals with incomes less than twice the official poverty level.
- Gives States the programmatic flexibility to increase health insurance coverage through support of private health coverage.
- Simplifies the waiver application process by providing clear guidance and data templates.
- Increases accountability in the State and Federal partnership by ensuring that Medicaid and SCHIP funds are effectively being used to increase health insurance coverage.

To date, HIFA waivers have been approved for Arizona, California, Colorado, Illinois, Maine, New Mexico, and Oregon. Of these seven waivers, six of them involve Title XXI funding and are also mentioned in the State Children's Health Insurance Program section.

B. Pharmacy Plus Waivers

The Administration is concerned that many low-income seniors and people with disabilities are not able to afford prescribed drugs and that failure to take these drugs may result in more serious and costly health problems. To address this concern, the Administration developed the Pharmacy Plus waivers under section 1115. Pharmacy Plus is directed to Medicare beneficiaries and other low-income seniors and people with disabilities with income at 200 percent or less of the federal poverty level (FPL) who are not eligible for full Medicaid benefits. States have flexibility to design their benefit package, including the types of drugs covered, beneficiary copayment requirement, limits on the numbers of prescriptions covered, or monthly costs reimbursed.

Four states have approved Pharmacy Plus waivers (Florida, Illinois, South Carolina, and Wisconsin) and Maryland has revised its statewide 1115 demonstration to add a pharmacy benefit. Eight other states have applications pending.

CMS meets its fiduciary responsibilities by requiring that all health care reform demonstrations be budget neutral, i.e., Federal expenditures under the demonstration may be no more than they would have been absent the demonstration.

OTHER APPROPRIATED ACCOUNTS

VII. Rationale for the Budget Estimate**A. Medical Assistance Payments (MAP)**

In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2002 State estimates. These adjustments reflect actuarial estimates, recent regulatory and legislative impacts, Medicaid financial disallowances, financial management reviews, and the Vaccines for Children program.

1. Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2002 State estimates for medical assistance payments (MAP) of \$161.1 billion in FY 2004 are the first State-submitted estimates for FY 2004. Typically, State estimation error is most likely to occur early in the budget cycle because most States are focused on their current year budget and have not yet focused on their projections for the Federal budget year.

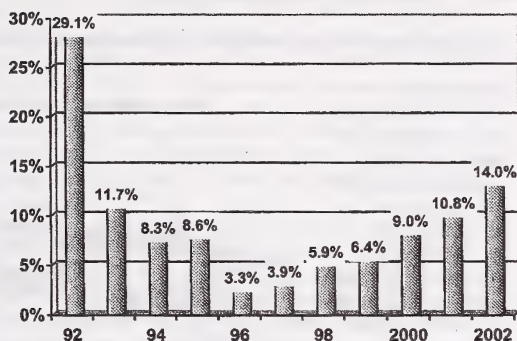
CMS's Office of the Actuary developed the MAP estimate for FY 2004. Using the first three quarters of FY 2002 State-reported expenditures as a base, expenditures for FY 2003 and FY 2004 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by the Office of Management and Budget and demographic trends in Medicaid enrollment. Based on this information, CMS's Office of the Actuary increased the States' medical assistance payment estimates for FY 2004 by \$6.3 billion to \$167.4 billion.

A significant part of historical growth in Medicaid program costs during the early 1990's was a result of growth in disproportionate share hospital (DSH) payments and associated provider tax and donation programs, significant Medicaid enrollment increases, and medical price inflation. In the mid 1990's, these cost factors began to moderate as a result of an improving economy, legislative restrictions on tax and donation programs and DSH payments, and welfare reform, resulting in slower program outlay growth, averaging about 3.5 percent in FY 1996 and FY 1997. In the late 1990's, however, outlays began to accelerate again, growing at an average rate of about 9.2 percent since FY 1997, reaching 14 percent in FY 2002. Much of this growth is attributable to accelerating caseloads in recent years. Prescription drug spending, nursing home costs, and community-based long-term care costs have

OTHER APPROPRIATED ACCOUNTS

also been significant contributors to this expenditure growth and are expected to continue to contribute to program growth in future years. State programs providing “enhanced payments” to institutional providers have also played a significant role in driving up Medicaid costs at an accelerated rate. We anticipate that recent regulations will eventually curtail much of the impact of these payments.

MEDICAID OUTLAY GROWTH RATES



2. Other Adjustments to the State Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews

(estimated FY 2004 savings are \$336.0 million)

Financial management (FM) reviews conducted by regional office staff are expected to produce savings of \$307.0 million in FY 2003 and \$336.0 million in FY 2004. CMS is committed to re-instituting a more structured FM review process that will increase the level of FM oversight activities. Core activities of the FM process include the quarterly on-site reviews and processing of Medicaid budget and expenditure reports, performance of detailed FM reviews of specific high-risk areas, and other on-going oversight/enforcement activities such as deferrals, disallowances, audit resolution, and financial data and information gathering.

OTHER APPROPRIATED ACCOUNTS

Disallowances for Prohibited Provider Taxes
(estimated FY 2004 savings are \$357.9 million)

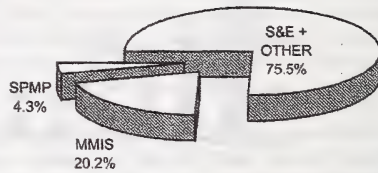
On January 19, 2001, CMS disallowed Federal funds in States that imposed impermissible nursing facility taxes. All these States have now terminated these impermissible arrangements.

The affected States have appealed the disallowance action(s) to the Departmental Appeals Board (DAB).

B. State Estimates for State and Local Administration (ADM)

In November 2002, the States estimated the Federal share of State and local administration to be \$8.2 billion for FY 2003 and \$8.3 billion for FY 2004, a growth of only 1.8 percent. The FY 2004 estimate is composed of \$1.7 billion for

STATE ESTIMATES FOR FY 2004



Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems, and non-MMIS automated data processing activities; \$0.3 billion for skilled professional medical personnel (SPMP); and \$6.3 billion for salaries, fringe benefits, training, and other State and local administrative costs as shown. These other costs include, quality improvement organizations, pre-admission screening and resident review, nurse aide training and competency evaluation programs, and all other general administrative costs.

CMS adjusted the FY 2004 State-submitted estimates of \$8.3 billion to compensate for recent State underestimation of State and local administration costs and to reflect a growth more consistent with recent expenditure growth (+\$356.6 million). CMS also subtracted \$5.9 million for overestimation in the State-submitted estimates of the HIPAA administrative simplification rule provision impacts. The States had included \$106.9 million in their FY 2004 estimates. After these adjustments, the State and local administration for FY 2004 is estimated to be \$8.7 billion, or 1.7 percent higher than the CMS adjusted FY 2003 estimate.

OTHER APPROPRIATED ACCOUNTS

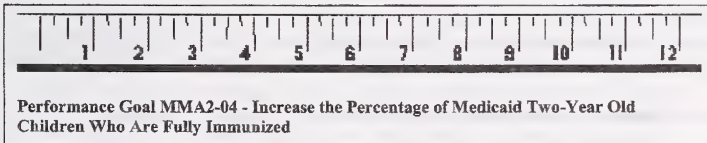
Adjustments to the State Estimates for State and Local Administration Due to Regulation**Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification Regulation**
(estimated FY 2004 spending is \$101 million)

The administrative simplification regulation was required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This regulation promotes the greater use of electronic transactions and the elimination of inefficient paper forms. It establishes standard data content and formats for submitting electronic claims and other administrative health transactions. Under this regulation all electronic claims transactions must follow the single standardized format. The regulation also includes new standards for other common transactions and coding standards for reporting diagnoses and procedures in the transactions. The regulation also outlined a process for maintaining the format and content of the standard transactions system.

The original deadline for compliance with the electronic transaction rule was October 16, 2002, for all covered entities except small health plans, which by law had an additional year. Last year, in the Administrative Simplification Compliance Act, Congress authorized a 1-year extension to October 16, 2003, for those covered entities required to comply in 2002. Covered entities submitted an extension plan to obtain this extension.

C. Vaccines for Children Program

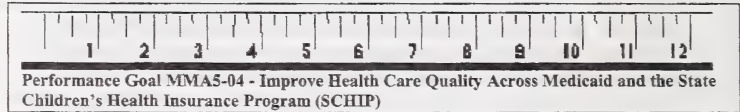
The current FY 2004 estimate for the Vaccines for Children (VFC) program is \$980.2 million. This represents a decrease of \$76.0 million from the current FY 2003 estimate of \$1,056.2 million.

**D. Medicaid State Survey and Certification**

The purpose of survey and certification inspections for nursing facilities and intermediate care facilities for the mentally retarded in FY 2004 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2004 estimate for Medicaid State survey and certification

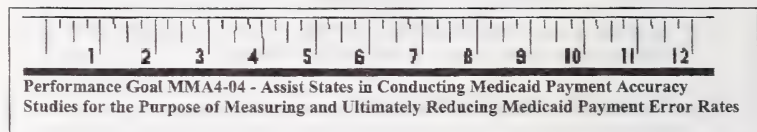
OTHER APPROPRIATED ACCOUNTS

is \$242.8 million. This represents an increase of \$14.2 million above the current FY 2003 estimate of \$228.6 million. This increased funding level will support increasing workload requirements and costs associated with survey and certification activities, to include the direct State survey costs associated with ensuring nursing home quality. During FY 2004, the Federal Medicaid survey and certification funding support for Nursing Home Oversight Improvement Program activities is projected at \$44 million.



E. State Medicaid Fraud Control Units

In FY 2004, State Medicaid fraud control unit operations are estimated to require \$124.8 million. This represents an increase of \$4.5 million over the FY 2003 funding level of \$120.3 million.



VIII. Impact of Proposed Legislation

A number of legislative proposals are being presented. The proposals include a major reform of Medicaid and the State Children's Health Insurance Program (SCHIP), as well as other legislative proposals. The other legislative proposals are described below.

A. Medicaid Prescription Drug Proposal

Pharmaceutical manufacturers must pay a rebate, shared between the States and Federal government, on prescription drugs dispensed to Medicaid beneficiaries. Under current law, this rebate equals the larger of 15.1 percent of the average manufacturer's price (AMP) or the difference between AMP and the manufacturer's best price.

Over the past year, it has become evident that the best price component of the rebate can be confusing, as it is not always clear which prices a manufacturer

OTHER APPROPRIATED ACCOUNTS

must include when calculating and reporting to CMS its best price. In addition, best price may serve to limit the discounts that private-sector purchasers are able to negotiate with pharmaceutical manufacturers.

Unlike the FY 2003 President's budget, the FY 2004 President's budget does not include any specific proposals with respect to Medicaid drug coverage and payment. Instead, the Administration would like to work with the relevant Congressional Committees on a policy that will increase the efficiency of Medicaid drug coverage and payment.

Five-year budget impact: Savings of \$5 billion

Ten-year budget impact: Savings of \$13.2 billion

B. Spousal Exemption

This legislative proposal would continue Medicaid eligibility under section 1619 of the Social Security Act for spouses of disabled individuals who return to work in the same duration and manner as Medicaid eligibility for the disabled individuals themselves.

Five year budget impact: \$95 million

Ten year budget impact: \$238 million

C. New Freedom Initiative

This legislative proposal would re-propose three demonstrations that are part of the New Freedom Initiative. The demonstrations will increase family supports, provide access to respite services, and allow States to serve children with serious emotional disturbances in community settings. The three demonstrations are:

- *Community Alternative to Children's Residential Treatment Facilities-* Enabling States to offer home and community-based services to children who would otherwise be served in psychiatric residential treatment facilities (RTFs). This demonstration would permit the delivery of intensive mental health services for children in their homes and communities and allow the Department to evaluate the cost of providing these services outside of RTFs.
- *Respite for Caregivers of Adults-* Allowing States to include respite care coverage as a Medicaid service under a capped budget. The demonstration will test whether respite care, or temporary care that offers support to family caregivers, will reduce caregiver "burn out" that often leads to institutionalization.

OTHER APPROPRIATED ACCOUNTS

- *Respite for Caregivers of Children with a Disability*- A similar demonstration will allow States to provide respite care to caregivers of children with substantial disabilities. This demonstration will enable HHS to collect specific data about the cost and utilization of respite services for caregivers of children.

Five year budget impact: \$217 million

Ten year budget impact: \$778 million

D. “Money Follows the Individual” Re-balancing Demonstration

This legislative proposal would create a five-year demonstration that finances services for individuals who transition from institutions to the community. Federal grant funds would pay the full cost of home and community-based waiver services for one year, after which the participating States would agree to continue care at the Medicaid matching rate. By providing services to help individuals live full lives in the community, and by requiring States to reduce institutional long-term care spending, either by converting nursing facility beds to home and community based services waiver slots or through other mechanisms, this proposal supports the President’s New Freedom Initiative and the Executive Order on the implementation of the Supreme Court’s *Olmstead* decision.

Five year budget impact: \$1.75 billion

Ten year budget impact: \$1.75 billion

E. Presumptive Eligibility for Community-Based Services

This legislative proposal would establish a State option enabling Medicaid presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community. Allowing presumptive eligibility for this group is intended to increase the number of Medicaid beneficiaries able to make the transition from institutional care to home and community-based services.

Budget Impact: Negligible.

F. Pay Nursing Homes Directly for Services to Residents Electing Hospice Care

When a resident of a nursing home chooses hospice care, Medicaid law requires States to pay hospice programs, not only for the hospice services they provide, but also for the room and board and related care provided by the nursing home. The hospice program then passes along payment to the nursing home. The Administration proposes to change this requirement so that States would pay

OTHER APPROPRIATED ACCOUNTS

each provider, the hospice program and the nursing home, directly for the care it furnishes. This would reduce the administrative burdens on States and hospice programs, permit faster payments to nursing homes, and assure that each provider is paid the correct amount.

Five-year budget impact: None

Ten-year budget impact: None

G. Extend SCHIP Funds

Please refer to the State Children's Health Insurance Program section for the description of this proposal.

H. Additional Funding for VFC Program

In 1995, the Federal government established a reliable and efficient method for central acquisition of routine childhood vaccines for Medicaid-eligible, uninsured, and underinsured children. Three improvements are being proposed. First, the statutorily required stockpile would be filled in ways that ensure against supply disruption. Second, the price cap on tetanus-diphtheria booster will be lifted so that VFC-eligible children can receive the vaccine. The price cap has discouraged manufacturers from selling this vaccine to VFC. Third, VFC-eligible underinsured children would be assured greater access to vaccines by permitting VFC payments to State and local public health departments (in addition to community health centers and Federally-qualified health centers).

Five-year budget impact: \$810 million

Ten-year budget impact: \$1.61 billion

I. Extend and Simplify Transitional Medical Assistance

Transitional Medical Assistance (TMA) was created to provide health coverage for former welfare recipients after they entered the workforce. TMA extends up to a year of health coverage to families who lose eligibility for welfare-related Medicaid due to earnings from employment. This provision was set to expire September 30, 2002 and is currently authorized by Congress via a continuing resolution. The Administration proposes a five-year extension.

The Administration also proposes to simplify TMA by providing States with the option to eliminate TMA reporting requirements and to provide 12 months of continuous TMA eligibility. This proposal would also waive TMA requirements for States in which the income eligibility level for families is

OTHER APPROPRIATED ACCOUNTS

already 185 percent of the Federal poverty level (FPL) or above and would provide TMA beneficiaries with a "health coupon" to purchase private health insurance.

Five year budget impact: \$2.69 billion

Ten year budget impact: \$2.69 billion

J. Extension of Premium Assistance for QI-1s

Medicaid currently pays Medicare premiums for certain qualifying individuals (QIs) -- low-income Medicare beneficiaries with incomes of 120-135 percent of poverty and minimal assets. This provision, which was scheduled to sunset in September 2002 (but has been carried forward from December 31, 2002 under a series of continuing resolutions), would be continued through FY 2008.

Medicaid would continue to pay Part B premium costs for QI-1s, with 100 percent Federal funding, subject to a spending limit. This benefit supports low-income elderly who otherwise would have to pay nearly six percent of their income for physician and other services under Medicare Part B.

Five year budget impact: \$645 million

Ten year budget impact: \$645 million

K. Special Enrollment Period in the Group Market for Medicaid/SCHIP Eligibles

This legislative proposal would make it easier for Medicaid and SCHIP beneficiaries to enroll in private health insurance, by making eligibility for Medicaid and SCHIP a trigger for private health insurance enrollment outside the plan's open season. This proposal will help States implement premium assistance programs in Medicaid and SCHIP.

Budget Impact: Negligible

L. SSA Disability Determinations

The Social Security Administration has proposed a management improvement initiative that has an impact on the Medicaid program. The proposal establishes a standard for accuracy in SSI disability awards identical to the one that applies to the Social Security Disability Insurance Program. This provision will help ensure that only individuals who are disabled will receive SSI disability benefits and related Medicaid coverage.

Five year budget impact: Savings \$215 million

Ten year budget impact: Savings \$1.227 billion

OTHER APPROPRIATED ACCOUNTS

M. Mandatory Review/Adjustment of Child Support Orders

States would be required to review all aspects of all child support cases at least once every three years. More frequent case reviews will lead to more children being awarded health insurance coverage as part of their child support award. As a result, some children will no longer need Medicaid at all, while others will still be eligible for Medicaid but will rely mainly on private insurance to pay their bills.

Five-year budget impact: Savings \$40 million

Ten-year budget impact: Savings \$210 million

N. Tax Credits for Health Insurance

This proposal provides a refundable tax credit for low- and middle-income level Americans to purchase health insurance coverage in the individual market. The credit, which would not be limited to Medicaid recipients, would subsidize up to 90 percent of coverage for lower income families (\$89 billion over ten years). The Department of the Treasury's *General Explanations of the Administrations' Fiscal Year 2004 Revenue Proposals* (known as the Blue Book) explains all of the Administration's tax proposals.

OTHER APPROPRIATED ACCOUNTS

Payments to the Health Care Trust Funds**Appropriation Language**

For payment to the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as provided under section 1844 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, \$95,084,100,000.

OTHER APPROPRIATED ACCOUNTS

Amounts Available for Obligation
(dollars in thousands)

	<u>FY 2002</u> <u>Actual</u>	<u>FY 2003</u> <u>President's Budget 1/</u>	<u>FY 2004</u> <u>Estimate</u>
Appropriation:			
Annual	\$81,979,200	\$81,471,216	\$95,084,100
Funds Lapsing:			
Program Management			
administrative expense	-2,781	---	---
Federal payment for SMI	-3,014,244	---	---
Payback in FY 2002 for FY 2001 shortfall (with interest, non-add)	[1,612,011]	---	---
Anticipated shortfall (not appropriated; non-add)	---	[2,999,000]	---
Anticipated payback for FY 2003 shortfall (with interest, non-add)	---	---	[3,035,000]
Total			
Obligations	\$78,962,175	\$81,471,216	\$95,084,100

1/ This column reflects the current estimate for FY 2003. The appropriation amount is the same as the FY2003 President's Budget. The current estimate reflects an anticipated shortfall of \$2,999,000,000.

OTHER APPROPRIATED ACCOUNTS

Summary of Changes

2003 President's Budget	\$81,471,216,000
2004 Estimate	<u>\$95,084,100,000</u>
Net Change	<u>+\$13,612,884,000</u>

	FY 2003 <u>President's Budget</u>	FY 2004 <u>Change From Base</u>
Changes:		
1. Federal Payment for Supplementary Medical Insurance	\$80,905,000,000	+\$13,613,000,000
2. Hospital Insurance for the Uninsured	225,000,000	-28,000,000
3. Hospital Insurance for Uninsured Federal Annuitants	168,000,000	0
4. Program Management Administrative Expenses	<u>173,216,000</u>	<u>+27,884,000</u>
Net Change	\$81,471,216,000	+\$13,612,884,000

OTHER APPROPRIATED ACCOUNTS

Budget Authority by Activity

(dollars in thousands)

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>
Supplementary Medical Insurance	\$81,332,000	\$80,905,000	\$94,518,000
Hospital Insurance for the Uninsured	292,000	225,000	197,000
Hospital Insurance for Uninsured Federal Annuitants	150,000	168,000	168,000
Program Management Administrative Expenses	205,200	173,216	201,100
Total Budget Authority	\$81,979,200	\$81,471,216	\$95,084,100

OTHER APPROPRIATED ACCOUNTS

Budget Authority by Object
(dollars in thousands)

	FY 2002 <u>Actual</u>	FY 2003 <u>President's Budget</u>	FY 2004 <u>Estimate</u>
Grants, subsidies and contributions	\$81,332,000	\$80,905,000	\$94,518,000
Insurance claims and indemnities	442,000	393,000	365,000
Undistributed 1/	<u>205,200</u>	<u>173,216</u>	<u>201,100</u>
Total Budget Authority	\$81,979,200	\$81,471,216	\$95,084,100

1/ This activity, which pays back the HI Trust Fund for funds advanced on behalf of the General Fund, is reported in the Object Class schedule as "undistributed". This is done to prevent duplicate reporting of these costs which are accounted for in the Program Management Object Class schedule.

OTHER APPROPRIATED ACCOUNTS

General Statement

The annual appropriation for the Payments to the Health Care Trust Funds account makes payments from the General Fund to the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds. These payments make the trust funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.

Through this appropriation, the trust funds are made whole for Medicare benefits, administrative costs, and related interest for payments made on behalf of beneficiaries who were not insured for Medicare at the beginning of the program but were deemed to be so under transitional provisions of the law. Similarly, the appropriation makes the trust funds whole for costs related to civil service annuitants who earned coverage for Medicare under transitional provisions enacted when Medicare coverage was first extended to Federal employees. This appropriation also reimburses the HI Trust Fund for that portion of the administrative costs of the Centers for Medicare & Medicaid Services, initially borne by the Hospital Insurance Trust Fund, which is properly chargeable to general funds, e.g., Federal administrative costs for the Medicaid program.

This appropriation also includes the Federal match for premiums paid by or for individuals voluntarily enrolled in the SMI program, also referred to as Part B of Medicare. The Part B premium for all beneficiaries is currently set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries. The Federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled beneficiaries.

Federal Contribution for SMI

The estimate of \$94.5 billion for the FY 2004 Federal Contribution for SMI is a net increase of \$13.6 billion over the FY 2003 appropriation request. The cost of the Federal match continues to rise from year to year because of beneficiary and program growth.

OTHER APPROPRIATED ACCOUNTS

The following table of the SMI Federal contribution share of the appropriation displays the adjustments in FY 2002 and the relationship to the FY 2004 appropriation request:

(dollars in thousands)

	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
Amount needed for Federal SMI contribution (prior to adjustments)	\$76,705,745	\$80,905,000	\$91,483,000
Adjustments:			
Payback in FY 2002 for FY2001 Shortfall (with interest)	+1,612,011	---	---
Funds lapsing	+3,014,244	---	---
Anticipated shortfall (non-add; not appropriated)	---	[2,999,000]	---
Anticipated Payback for Shortfall (with interest, included in Annual appropriation)	---	---	<u>3,035,000</u>
Appropriation for Federal SMI contribution	\$81,332,000	\$80,905,000	\$94,518,000
Change from prior year			+\$13,613,000

OTHER APPROPRIATED ACCOUNTS

Hospital Insurance for the Uninsured

The FY 2004 estimate of \$197 million for Hospital Insurance for the Uninsured is \$28 million lower than the FY 2003 appropriation request of \$225 million. Because this payment is for a closed and shrinking population, the amount of this payment decreases each year.

Hospital Insurance for Uninsured Federal Annuitants

The FY 2004 estimate of \$168 million for Hospital Insurance for Uninsured Federal Annuitants is the same as the FY 2003 appropriation request. The FY 2004 estimate reflects an increase in the number of covered individuals who are currently enrolled.

Program Management Administrative Expenses

The FY 2004 estimate of \$201.1 million to reimburse the HI Trust Fund for Program Management administrative expenses is \$27.9 million more than the FY 2003 appropriation request of \$173.2 million.

OTHER APPROPRIATED ACCOUNTS

Permanent Budget Authority by Activity

A permanent indefinite appropriation of general funds for the taxation of Social Security benefits is made to the HI Trust Fund through the Payments to Health Care Trust Funds account. In addition, the following permanent appropriations associated with the Health Care Fraud and Abuse Control (HCFAC) account will pass through the Payments to the Health Care Trust Funds account: FBI, Criminal Fines, and Civil Monetary Penalties.

(dollars in thousands)

	FY 2002	FY 2003	FY 2004
	<u>Actual</u>	<u>President's Budget 1/</u>	<u>Estimate</u>
Tax on OASDI Benefits	\$10,946,000	\$7,780,000	\$8,348,000
HCFAC, FBI	101,000	114,000	114,000
HCFAC, Criminal Fines	440,000	4,000	4,000
HCFAC, Civil Monetary Penalties	0	7,000	7,000
Permanent Budget Authority	\$11,487,000	\$7,905,000	\$8,473,000

1/ This column reflects the current estimate for FY 2003. Budget authority in the FY 2003 President's budget was \$8,866,900,000. The principal reason for the decrease is a lower estimate related to Tax on OASDI.

OTHER APPROPRIATED ACCOUNTS

Health Maintenance Organization Loan and Loan Guarantee Fund

Appropriation Language

For carrying out subsections (d) and (e) of section 1308 of the Public Health Service Act, any amounts received by the Secretary in connection with loans and loan guarantees under title XIII of the Public Health Service Act, to be available without fiscal year limitation for the payment of outstanding obligations. During fiscal year 2004, no commitments for direct loans or loan guarantees shall be made.

 OTHER APPROPRIATED ACCOUNTS

 HEALTH MAINTENANCE ORGANIZATION
 LOAN AND LOAN GUARANTEE FUND

Language Analysis

Language Provision	Explanation
<i>For carrying out subsections (d) and (e) of section 1308 of the Public Health Service Act, any amounts received by the Secretary in connection with loans and loan guarantees under title XIII of the Public Health Service Act, to be available without fiscal year limitation for the payment of outstanding obligations.</i>	Makes receipts of the fund available for the payment of obligations, i.e., prepayment premiums and interest subsidies.
<i>During fiscal year 2004, no commitments for direct loans or loan guarantees shall be made.</i>	This provision prohibits the issuance of additional direct loans or loan guarantees to health maintenance organizations from the Health Maintenance Organization Loan and Loan Guarantee Fund.

OTHER APPROPRIATED ACCOUNTS

GENERAL STATEMENT

The Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund served as a mechanism to provide working capital to HMOs in their initial operating periods when financial deficits were expected. During the 1970's, direct loans were made to HMOs from the Fund. These loans were then sold, with guarantees, to the Federal Financing Bank (FFB). The Fund also guaranteed the repayment of loans made by private lenders to HMOs.

Because the Health Care Financing Administration (HCFA), now known as the Centers for Medicare & Medicaid Services (CMS), was becoming increasingly responsible for coordinated care, the Public Health Service's HMO program was transferred to HCFA in 1985. Included in this transfer was the HMO Loan and Loan Guarantee Fund.

The HMO Loan and Loan Guarantee Fund is now dormant. The last loan commitments were made in 1983. In its period of active operation, the fund operated as a revolving fund. Direct loans to HMOs were sold, with a guarantee, to the FFB. The FFB purchase proceeds were then used as capital for additional direct loans.

In the past, CMS collected principal and interest payments from HMO borrowers, and in turn paid the FFB. When loans were prepaid, CMS rarely collected a prepayment penalty because most of the loan agreements did not have a prepayment penalty clause. However, when CMS repaid the loan to the FFB, a prepayment penalty was incurred, and an obligation was created.

In FY 1995, the Congress appropriated \$15 million to the HMO Loan and Loan Guarantee Fund so that repayments could be made to the FFB. It is no longer necessary, however, to make repayments because the FFB has been paid in full for the loans.

Currently, the unobligated balance in the Fund is \$10.5 million. It is anticipated that this balance will be withdrawn at the end of FY 2004 and the account will expire.

Section IV Contents

PRESIDENT'S MANAGEMENT AGENDA

President's Management Agenda Summary	IV-1
---	------

President's Management Agenda -- Policy

HUMAN CAPITAL

1. Background & Overview of FY 2002/2003 Activities

In November 2001, the Centers for Medicare & Medicaid Services (CMS), in conjunction with the Department of Health and Human Services (DHHS), developed a 2-year *Action Plan* designed to support the objectives outlined in *The President's Management Agenda*. This inaugural *Action Plan* covered the period October 1, 2001 through September 30, 2003, and focused on key human capital management areas such as consolidating administrative functions, organizational de-layering and restructuring, competitive sourcing, FTE reduction, hiring restrictions, and recruitment and hiring.

To date, CMS and DHHS have met with considerable success in using the *Action Plan* as the foundation for attaining many of the objectives outlined in *The President's Management Agenda*. For example, in FY 2002, CMS identified 16 organizations that exceeded the maximum target level of four management layers and completed de-layering efforts in all 16 areas. In the area of consolidation, all CMS administrative functions (e.g., budget/financial management, human resource management, public affairs, and legislative affairs) were either consolidated or determined to be operating at a necessary level of separation due to legitimate business considerations. Further, CMS has worked closely with DHHS to consolidate its human resources management, public affairs, and legislative affairs functions; we anticipate that each of these consolidation efforts will be concluded before the end of FY 2003.

In May 2002, CMS's multiple information technology (IT) infrastructure support contracts were merged into a consolidated contract. In FY 2003, CMS will continue to conduct detailed workforce analysis and planning related to its IT workforce and organizational structure, and will also focus on the relationship between these issues and the consolidated IT contract. CMS also made significant progress in eliminating a number of administrative positions (e.g., facilities management and human resources) via redeployment and attrition during FY 2002, and we are confident that we will fully meet the FY 2003 target of 93 administrative position reductions through the use of Voluntary Early Retirement Authority (approved for the period October 1, 2002 - September 30, 2003), as well as through additional attrition and re-deployments.

Because of our successes with the earlier *Action Plan*, and because we anticipate that many of the key issues facing CMS in FY 2004 will be closely related to issues existing in FY 2002 and FY 2003, the underlying principles and approaches employed in that original plan have served as a blueprint for developing the FY 2004 budget request and strategic human capital management planning initiatives. The information that follows provides an update on FY 2002/2003 restructuring activities and introduces CMS's FY 2004 *Strategic Management of Human Capital Action Plan* (the next iteration of the

 THE PRESIDENT'S MANAGEMENT AGENDA

original CMS *Action Plan*). The goal of this plan is to build upon earlier successes to achieve results consistent with the principles of *The President's Management Agenda*, i.e., to foster the effective management of the Agency's human capital in a citizen-centered, results-oriented, and market-based manner. CMS is committed to ensuring that the new plan supports and enhances completion of the work begun in FY 2002 – 2003, so that the success of these earlier efforts can ultimately be measured by actual performance and results, rather than just by the development of a well-intentioned plan.

2. FY 2002/2003 Restructuring Activities

By the end of FY 2003, CMS will reduce by 93 the number of staff performing certain administrative functions. These reductions will be accomplished through various restructuring activities, such as consolidation, attrition, and redeployment of staff to front-line program positions. In most cases, redeployed staff will require retraining. Additionally, to facilitate these reductions and avoid the need to undergo a reduction in force, CMS will offer voluntary early retirement to employees in the Human Resources Management Group, Learning Resources Group, Office of Equal Opportunity and Civil Rights (260 series) and Administrative Services Group, as well as employees occupying positions in the information technology (334, 2210) and general administrative, clerical and office services group (e.g., GS-301, GS-303, GS-318, GS-340, GS-341, GS-343, and GS-391). The window for voluntary early retirement is October 1, 2002, through September 30, 2003. Throughout this period, the Human Resources Management Group will be monitoring attrition against reduction goals. Reductions that are not met through attrition will be accomplished through redeployment. Below is a table illustrating the functional areas affected by these staff reductions and the estimated number of position reductions in each area to be accomplished via either attrition or redeployment.

Functional Area	Total Number of Positions Affected	Projected Method(s) of Reduction
Public Affairs	3	Attrition (2 positions) Redeployment (1 position)
Research	6	Attrition (3 positions) Redeployment (3 positions)
Information Technology	4	Attrition (4 positions)
Financial Management	4	Attrition (2 positions) Redeployment (2 positions)
Facilities Management	10	Attrition (4 positions); Redeployment (6 positions)
Human Resources Management	23	Attrition (13 positions); Redeployment (10 positions)
Administrative Management	43	Attrition (7 positions); Redeployment (36 positions)
TOTALS:	93	Attrition (35 positions); Redeployment (58 positions)

THE PRESIDENT'S MANAGEMENT AGENDA

3. Key Initiatives in the FY 2004 Strategic Management of Human Capital Action Plan

In FY 2004, we anticipate that the key human capital management focus will be enhancing the skills capacity in certain critical occupations such as information technology, clinical/health, and management/leadership. This will be accomplished through strategic initiatives in each of these major occupational areas.

Information Technology (IT)

CMS's IT workforce is almost 9 percent of the Agency's employment base and IT plays a key role in CMS's mission. Over the next several years, CMS's mission-critical operations will have an on-going need for state-of-the-art, highly secure Medicare databases, claims processing systems, web-based beneficiary information dissemination tools, etc.

CMS, together with the Department, will determine the steps needed to rectify skill mix issues. CMS will monitor staffing changes and develop a strategy for restructuring the organizations that perform IT work. CMS will backfill the necessary number of relevant positions to support the new IT environment.

Clinical/Health

Everything CMS does has a clinical implication. However, CMS's workforce planning initiative has identified a significant gap between the number of clinical/health care professionals currently on board and the number of such individuals needed to meet the mission critical needs of the Agency. We continue to experience difficulty with recruitment and retention of expert clinical professionals. CMS is committed to eliminating this critical skills gap over the next several years. CMS has developed a *Clinical Workforce Strategy* that includes a plan to fill this gap, and has recently announced a Health Scholars Program designed to foster a partnership between CMS and professional health care associations. We are hopeful that, through two programs, CMS will be able to significantly improve the skills capacity in the clinical/health areas.

Management/Leadership

Traditionally, CMS managers have been selected for their technical expertise rather than for their leadership and management skills. CMS's *Leadership and Management Development Strategy* (LMDS), an integrated, competency-based system that includes recruitment/selection, continuous learning, performance planning and appraisal, and rewards and recognition, is based on the theory that better managers will be more results-oriented and customer-focused.

In FY 2002, CMS implemented a competency-based recruitment and selection process for non-SES managers. During FY 2003, full implementation of competency-based performance appraisal and awards and recognition programs are scheduled to occur. In

FY 2004, CMS plans to establish baseline information on the level of proficiency of CMS's managers vis-à-vis the standard leadership competencies, determine those leadership competencies most frequently needed in CMS, and begin to track progress in retooling CMS's managerial workforce.

In summary, in FY 2002/2003, CMS's efforts in restructuring are focused on de-layering and consolidation of administrative functions with the aim of placing more of its resources in program areas that can have a direct impact on the customer. In FY 2004, CMS will focus on addressing skills imbalances in certain mission critical areas, including IT, clinical/health, and management/leadership, using current personnel flexibilities, along with special authorities such as voluntary early-out authority. Appendix A lists CMS's Action Plan, with milestones and target dates, for completing these restructuring activities. Appendix B includes a chart that illustrates the personnel flexibilities and special authorities used to accomplish CMS's restructuring objectives and the cost of implementing such tools.

4. Linking Human Capital Management Practices to CMS's Strategic Objectives

CMS's Restructuring and Management Plan

On August 29, 2001, CMS implemented a comprehensive Restructuring and Management Plan (RAMP) to move the Agency toward being citizen-centered, results oriented, market aware, and effective. This plan meets OMB's objectives to deploy resources to direct-service delivery positions that interact with citizens and use workforce planning to flatten the Federal hierarchy, increase the span of control, and reduce the time it takes to make decisions. The RAMP focuses on six primary objectives: (1) restructuring, (2) integrating budget and performance, (3) enhancing strategic management of human capital, (4) increasing competitive sourcing, (5) improving financial performance, and (6) expanding electronic government—with each of these objectives having specific supporting projects/initiatives. CMS's recruitment and retention policies and hiring plans directly link to the RAMP, thus supporting short- and long-term workforce needs.

Recruitment and Retention Strategies for Restructuring CMS

CMS faces numerous human capital challenges. These include the need for a different mix of skills and knowledge to implement new functions created by legislation, an expected doubling of annual retirements due to an aging workforce, and continuous learning required to keep up with new information and health care technologies.

CMS's recruitment and retention strategies are based on data that reflect the size, age, and diversity of the workforce, as well as projected retirements and turnover. Recruitment initiatives currently underway, that are expected to continue through FY 2004, include the *Clinical Workforce Strategy*, *Health Scholars Program*, increased usage of student and internship programs, partnerships with professional, educational and minority organizations, the establishment of a special recruitment team to attract

THE PRESIDENT'S MANAGEMENT AGENDA

high quality staff, and an overall increased emphasis on diversity. To enhance retention, CMS has a strong orientation program, a formal mentoring program, and has implemented an exit interview process, as well as a new employee survey. If CMS is to meet its current and future human capital challenges, continued efforts must be placed on the recruitment and retention of critical skills. As CMS continues to strengthen its capacity in these areas, the Department's action plan for recruitment and retention will serve as a blueprint for developing further strategies.

FY 2003/2004 Hiring Plans

The FY 2003 and FY 2004 hiring plans will continue to support CMS's critical mission needs and restructuring objectives, carefully considering which skills are needed to supplement the staff already on-board. The plans will also take into account projected attrition through normal separation, as well as through separation incentives with a continued focus on diversifying CMS's workforce. Finally, CMS will monitor all merit promotion actions to ensure compliance with CMS's RAMP.

Appendix A: FY 2003 and FY 2004 Action Plans: Major Milestones

Fiscal Year 2003

Milestone	Target Date
1. Announce Voluntary Early Retirement Authority (VERA) (Facilities Management, Human Resources, IT, and Administrative Management positions) for the period 10/01/02 through 09/30/03.	September 16, 2002
2. Develop CMS Hiring Plan for FY 2003.	February 28, 2003
3. Reduce organizational layers in CMS to no more than four management levels.	December 31, 2002
4. Analyze VERA attrition for the 10/01/02-09/30/03 period to determine staff re-deployments in the Human Resources, Facilities Management, and Administrative Management areas.	September 30, 2003
5. Use CMS's Office of Information Services' workforce planning study (scheduled for completion in Spring 2003), and factor in VERA attrition in IT functional areas and additional skill imbalance issues to determine actions necessary to address skill mix and balance issues.	September 30, 2003

Fiscal Year 2004

Milestone	Target Date
1. Develop process for gathering and analyzing baseline information relevant to CMS's FY 2002 -FY 2003 non-SES Managers' Performance Management System.	October 1, 2003
2. Develop CMS Hiring Plan for FY 2004.	October 15, 2003
3. Review CMS's <i>Clinical Workforce Strategy</i> to determine effectiveness and potential need for change.	October 15, 2003
4. Conduct evaluation of CMS's <i>Leadership and Management Development Strategy</i> with special emphasis on the effectiveness of "core competencies".	December 31, 2003
5. Readjust specialized IT hiring plan based upon final review of actual losses and other emerging issues.	May 1, 2004

THE PRESIDENT'S MANAGEMENT AGENDA

Appendix B: Human Capital Costs Associated with CMS Restructuring Initiatives
 Fiscal Years 2000 Through 2002

Flexibility Type	FY 2000 Positions Involved	FY 2000 Funds Involved	FY 2001 Positions Involved	FY 2001 Funds Involved	FY 2002 Positions Involved	FY 2002 Funds Involved
Recruitment Bonuses	3	\$47,874	2	\$36,552	4	\$81,835
Retention Allowances	5	\$80,717	6	\$87,132	6	\$179,191
Payment of Relocation Expenses	34	\$406,604	14	\$147,893	23	\$266,000
Tuition Reimbursement	N/A	\$47,670	N/A	\$234,554	N/A	\$145,151
PSP	2	\$35,209	3	\$53,485	4	\$134,578
PCA	22	\$550,000	28	\$635,000	27	\$621,000
Federal Career Intern Program	0	0	1	\$36,656	50	\$2,071,515
Presidential Management Intern Program	10	\$433,601	10	\$377,052	8	\$338,757
Outstanding Scholars	63	\$1,837,069	31	\$947,599	8	\$272,113
Co-op Program	20	\$701,606	10	\$264,354	6	\$206,135
Totals:	159	\$ 4,140,350	105	\$ 2,820,277	136	\$4,316,275

THE PRESIDENT'S MANAGEMENT AGENDA

Human Capital Costs Associated with CMS Restructuring Initiatives (cont.)
 Fiscal Years 2003 Through 2004

Flexibility Type	FY 2003 Positions Involved	FY 2003 Funds Involved	FY 2004 Positions Involved	FY 2004 Funds Involved
Recruitment Bonuses	4	\$60,000	0	\$0
Retention Allowances	6	\$85,000	0	\$0
Payment of Relocation Expenses	23	\$240,000	0	\$0
Tuition Reimbursement	N/A	\$145,000	N/A	\$240,000
PSP	4	\$80,000	4	\$80,000
PCA	30	\$700,000	32	\$750,000
Federal Career Intern Program	50	\$2,336,600	50	\$2,430,000
Presidential Management Intern Program	10	467,320	10	\$486,000
Outstanding Scholars	10	382,000	10	\$397,280
Co-op Program	20	934,640	20	\$972,026
Incentives	0	0	0	\$0
Student Loan Repayments	17	\$100,000	0	\$0
Assessment and Selection Tools	0	0	N/A	\$0
Automated Position Classification & Staffing	0	\$90,000	N/A	\$0
Health Scholars Program (IPAs)	5	\$500,000	5	\$500,000
Totals:	179	\$6,530,560	131	\$5,855,306

THE PRESIDENT'S MANAGEMENT AGENDA

COMPETITIVE SOURCING

OMB Circular A-76 and the Federal Activities Inventory Reform (FAIR) Act of 1998 require each Federal agency to compile an inventory, by June 30 of each year, which classifies its activities as commercial, core commercial, or inherently governmental. The inventory is the basis for competitive sourcing. Agencies are required to conduct reviews of commercial activities to determine if it would be more efficient and cost beneficial to contract out, or outsource, the commercial activity to the private sector.

CMS submitted its FY 2003 competitive sourcing plan to the Department in May 2002. This plan identified 17 functions (315 FTEs) that would be subject to competitive sourcing studies. These studies began in October 2002 and will continue through September 30, 2003. In addition, CMS submitted its FY 2003 FAIR Act inventory to the Department on June 30, 2002. This inventory, which was published in the Federal Register in November 2002, identified 3,222 positions as inherently governmental and 1,297 positions as commercial. It should be noted that 122 positions were transferred from CMS's FAIR Act inventory to the Department as a result of the Department's consolidated Human Resource initiative.

On December 2, 2002, CMS submitted its FY 2004 competitive sourcing plan to the Department. This plan identified 17 functions (210 FTEs) that will be subject to a competitive sourcing study in FY 2004. The FY 2004 competitive sourcing inventory will be submitted to the Department by June 30, 2003. FY 2004 competitive sourcing studies will begin in October 2003 and end by September 30, 2004.

FINANCIAL MANAGEMENT

Improving financial performance is a top management priority at CMS. CMS continues to make significant improvements especially in the areas of timeliness, reliability, and accountability, and are planning many more. The following narrative summarizes CMS's current activities and future plans to implement improved financial performance. It focuses on five areas: erroneous payments, financial management improvement, financial systems, accountability, and integration of financial and performance systems.

Erroneous Payments: We have implemented aggressive efforts to reduce fraud and abuse in both the Medicare and Medicaid programs.

- o Medicare: One of CMS's key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers, for covered, reasonable, and necessary services provided to eligible beneficiaries. CMS has made significant progress in reducing the Medicare fee-for-service (FFS) error rate. CMS has an on-going program to track and report erroneous payments in FFS Medicare utilizing an audit performed by the Office of Inspector General (OIG). The OIG found that the error rate decreased by more than half, from 14 percent in FY 1996 to 6.3 percent in FY 2002.

THE PRESIDENT'S MANAGEMENT AGENDA

CMS plans to continue its program integrity (PI) strategies to reduce the error rate, and increase efficiency, effectiveness, and consistency in the application of Medicare coverage and payment rules. This strategy is two-pronged: directing CMS's efforts to educational initiatives that will assist providers in submitting error-free claims and remaining vigilant in the oversight of claims payments through data-driven statistical analyses. CMS now contracts with specialized contractors, Program Safeguard Contractors, that perform some or all of the work associated with medical review, cost report audits, data analysis, provider education, and fraud detection and prevention. Working with these contractors, CMS is developing better methods of measuring fraud, waste, and abuse in the Medicare program. CMS has developed a provider compliance rate (PCR) to measure the appropriateness of claims submitted prior to payments. In addition, CMS developed a Comprehensive Error Rate Testing (CERT) program that will calculate contractor, provider, and benefit specific error rates that can be aggregated to produce national-level estimates similar to the Medicare FFS error rate, but with greater precision. Both PCR and CERT were implemented simultaneously in three phases.

As part of the Medicare Secondary Payer (MSP) program, CMS maintains a comprehensive health care insurance profile on all Medicare beneficiaries that enables Medicare to pay the appropriate amount when beneficiaries also have private health insurance coverage, and seeks to recover improper or excess program payments. In FY 2002, CMS's efforts in the MSP area saved the Medicare trust funds approximately \$4.3 billion. CMS continues to work with the Department of Justice to include repayments to the trust funds when a product liability suit is brought against a manufacturer. We also now have a single entity, the Coordination of Benefits contractor, who maintains the health care insurance profile; previously, this profile was maintained and updated by 50 Medicare contractors.

- o Medicaid and State Children's Health Insurance Program (SCHIP): CMS is committed to assisting interested States in developing methodologies and conducting pilot studies to reduce Medicaid and SCHIP payment error rates. In FY 2002, 9 States participated in a Medicaid Payment Accuracy Measurement (PAM) pilot. The model will be pilot tested in 12 states in FY 2003. We anticipate expanding this up to 25 States in FY 2004. Beginning FY 2003, CMS will develop a similar error rate pilot project for the SCHIP program. The data from these studies will be used to help refine payment accuracy measurement methodologies and assess the feasibility of constructing a single methodology that can be used by all States.

Financial Management Improvement:

- o Accelerated financial reporting deadlines: CMS will meet the accelerated financial reporting deadline of February 1 for FY 2002 and FY 2003. CMS is reviewing business processes to identify areas that can be re-engineered to meet the November 15 deadline for FY 2004. CMS is planning to accelerate the FY 2003 deadline as a bridge to meeting the FY 2004 deadline.

 THE PRESIDENT'S MANAGEMENT AGENDA

In FY 2002, CMS continued to improve the financial statement reporting process within CMS central office. All financial data, including data provided by the Department of the Treasury and other Federal agencies, was included in CMS's general ledger. This facilitated the timely preparation of the financial statements by eliminating manual entries into spreadsheets and also provided the auditors with a clearer audit trail. CMS completed the initiative of preparing automated formatted financial statements with the automation of all five principal financial statements. CMS also produced interim financial statements in FY 2002 and submitted financial statements through the automated financial statement system implemented by the Department. CMS also improved the operation of FACS by programming and successfully implementing 155 accounting enhancements.

- Comparative financial analyses and reporting: CMS has been successfully conducting comparative financial analyses. For example, CMS has implemented trend analysis to validate the financial data we report as well as the data reported by our Medicare contractors. During FY 2002, CMS used consultants to help in the development of analytical tools necessary to perform more expansive trend analysis of critical financial data, specifically accounts receivable and semi-annual financial statements. These tools provide CMS with the steps necessary to identify unusual variances and potential areas of risk. They also allow CMS to perform more extensive data analyses, follow up with Medicare contractors, and determine the need for additional actions to ensure that problems are adequately resolved.
- Accurate and timely financial information: CMS has been meeting its goal of preparing and submitting financial statements accurately and timely. CMS received its first unqualified audit opinion on financial statements in FY 1999 and have maintained unqualified opinions since then. The auditor's opinion states that our financial statements "present fairly" CMS's financial position in accordance with generally accepted accounting principles.

Financial Systems:

- A key element of CMS's strategic vision is to implement a financial management system that is compliant with the Federal Financial Management Improvement Act of 1996 and will include all Medicare contractors. This project, called the Healthcare Integrated General Ledger Accounting System (HIGLAS), will provide CMS with a fully-functioning, integrated financial system and also replace CMS's administrative financial systems. Implementation of HIGLAS will give CMS enhanced oversight of contractor accounting systems and provide high quality, timely data for decision-making and performance measurement. It will also strengthen management of Medicare accounts receivable and allow more timely and effective collection of outstanding debts. In FY 2004, CMS is requesting \$57 million in 2-year money for HIGLAS. CMS estimates that this project will be completed by the end of FY 2007.

 THE PRESIDENT'S MANAGEMENT AGENDA

Accountability:

- o Obtain and retain timely unqualified audit opinion: CMS received unqualified audit opinions in FYs 1999, 2000, 2001, and 2002. HIGLAS should enable CMS to retain this unqualified opinion and resolve the financial systems material weakness identified in the audit.

In FY 2002, CMS spent \$4.9 million for external financial consultants on the CFO audit. This included costs of \$2.9 million for Ernst and Young and \$2.0 million for Clifton Gunderson LLP. CMS expects to spend approximately \$5.0 million in FY 2003 and \$5.2 million in FY 2004 for financial audits. The consultant contracts for FY 2003 and FY 2004 have not been awarded.

- o Comply with applicable laws and regulations: The auditor's opinion reflected no instances of non-compliance with laws and regulations, with the exception of the lack of a fully integrated financial management system.
- o Improve internal controls over financial reporting: The CFO audits have assisted in identifying two material weaknesses that limit CMS's ability to effectively manage the Medicare and Medicaid programs: (1) financial systems, analyses, and oversight and (2) Medicare electronic data processing controls. HIGLAS will resolve the first weakness, but it will be several years until this system is fully implemented. In the interim, CMS will continue to contract with CPA firms to conduct SAS 70 internal control reviews and accounts receivable reviews of Medicare contractors. The CMS teams also conducted accounts receivable reviews at selected Medicare contractors, using a standard review protocol to ensure that the reviews were consistent. To ensure that exceptions were addressed, CMS requested that the contractors develop and submit corrective action plans (CAP). The consultants, as well as CMS staff, followed up on contractor CAPs during subsequent reviews. Regional office systems security staff visited Medicare contractors to ensure that EDP problems were corrected. CMS also requires all Medicare contractors to submit an annual Certification Package for Internal Controls (CPIC) on their Medicare operations. In the CPIC, contractors are required to report their material weaknesses and reportable conditions. CMS requires CAPs for all material weaknesses reported in the CPICs. CPA firms review the CPICs.

The CFO auditors continue to identify an internal control weakness in contractors' reconciliations of their Funds Expended Reports to their paid claims tapes. Contractors are now required to submit this reconciliation to CMS monthly. CMS also issued a statement reiterating policy on reconciliation requirements and drafted a new review protocol that has been tested at two contractor locations.

Since 2000, CMS has been making significant progress in improving information systems security at the Medicare contractor sites. Despite this progress, recent self-assessments; as well as audits initiated by OIG, have revealed that the Medicare contractors fall substantially short of meeting a set of core security requirements based on various Federal laws and regulations. In FY 2001, CMS conducted a

 THE PRESIDENT'S MANAGEMENT AGENDA

comprehensive security assessment at its Medicare contractors to determine compliance with NIST, GAO, OMB, and legislative requirements, and to assess security risks and vulnerabilities. That assessment identified numerous systems control weaknesses. These weaknesses were documented in the *HHS Inspector General's Report on the HHS Consolidated/Combined Financial Statements for FY 2001*, with specific problems related to access controls and systems software issues. Because of the volume and sensitivity of personally-identifiable data, CMS assumes significant risk in not remediating known vulnerabilities.

The assessment performed at the Medicare contractors identified access controls as the area having the most security gaps. This assessment was validated through IV&V of the self-assessment results, and was further supported by the latest OIG audit in which 154 of the 245 security weaknesses identified at the Medicare contractor sites involved access controls. Another area of non-compliance that has been a recurring finding in OIG audits is the lack of Systems Security Plans (SSP) at virtually all Medicare contractors. In accordance with OMB Circular A-130, "Management of Federal Information Resources," Appendix III, updated in 1996, and Public Law 100-235, The Computer Security Act of 1987, the Medicare contractors are required to have SSPs. Each SSP represents a profile of systems security at each contractor site, identifying the current threats and vulnerabilities, as well as all safeguards already in place.

CMS applied \$14 million in FY 2002 to begin to address these security gaps. The FY 2003 budget request contains no more than \$2 million to continue this risk mitigation effort. CMS also spent \$4.2 million in FY 2002 to develop SSPs for these systems. CMS is requesting \$34 million in FY 2004 through its multi-year Revitalization Plan. This investment will enable CMS to address the most serious known security risks and vulnerabilities and to implement a robust ongoing security assessment program. CMS (and HHS) risks continued and increased criticism in delaying substantial risk mitigation of known security vulnerabilities. Until all security gaps are addressed the Department faces continuing risks of:

- unauthorized disclosure of personally identifiable health information;
- non-compliance with HIPAA security and other requirements; and
- material weaknesses in future CFO audits of the Medicare contractors.

Integration of Financial and Performance Systems:

- The Unified Financial Management System (UFMS) will replace five legacy accounting systems currently used across the DHHS operating divisions. The UFMS will integrate the Department's financial management structure and provide DHHS leaders with a more timely and coordinated view of critical financial management information. It will also promote consolidation of accounting operations, thereby reducing substantially the cost of providing accounting services throughout HHS. By generating timely, reliable, and consistent financial information, UFMS will enable program administrators to make more timely and informed decisions regarding their operations. CMS is requesting \$3.0 million to support this effort in FY 2004.

THE PRESIDENT'S MANAGEMENT AGENDA

EXPANDING E-GOV

CMS is committed to working with HHS and OMB to develop and implement a plan that supports the President's Management Agenda (PMA) e-gov goals. CMS is already taking a lead role in supporting HHS as the managing partner for the Consolidated Health Informatics (CHI) initiative, one of two OMB e-gov "QuickSilver" initiatives (along with E-Grants) for which HHS is the managing partner. The CHI initiative was received as a "business case only" initiative. A business case will be presented to the President's Management Council and the PMC will make a determination whether to support subsequent execution of the business case.

The CHI initiative will overcome the single most significant obstacle to government-wide health data interoperability – the lack of universal messaging and clinical health data standards. CHI will enable all Federal agencies to "speak the same language" by adopting a portfolio of existing health data interoperability standards for all Federal agencies to use within the Federal enterprise-wide business and technology architectures. CHI includes designing the change-management work needed following the adoption process to keep the enterprise-wide health data architecture viable. For the first time, CHI will "bring to the table" and institutionalize executive-level strategic and technical coordination among all Federal users of health information. Business partners are informed of our intent and decisions and given the opportunity to coordinate their business/technology architecture decisions and investments.

When completed, CHI would enable agencies to establish health enterprise architecture leading to the following benefits:

- The ability to capture health data at one point and allow reuse many times over;
- Faster and more complete electronic health records access resulting in fewer errors and lower administrative costs;
- Strengthened national public health efforts and disaster preparedness; and
- Improved quality in healthcare by accelerating clinical decision-making.

In addition to its managing partner role on CHI, CMS is proposing as part of its FY 2004 budget request to leverage the advances made by other OMB e-gov initiatives, specifically, on such issues as PKI, electronic signatures, and authentication. CMS intends to pilot solutions identified and developed within these initiatives within CMS's business operations, both internally (to effectively automate business processes) and externally (e.g., in Medicare claims processing operations). During FY 2003, CMS will be engaged in the development of specific plans to leverage these solutions and incorporate them into our target enterprise architecture that will guide investment decision-making during FY 2004.

CMS is also contributing in-kind labor resources to several other PMA e-gov initiatives: On-line Rulemaking, eAuthentication, eGrants, USA Services, GovBenefits and eVital. Given CMS's programmatic focuses and major systems responsibilities, great potential for leveraging results exists as these PMA initiatives deploy their solutions government-

 THE PRESIDENT'S MANAGEMENT AGENDA

wide. CMS monitors the work under all 24 initiatives to seek opportunities for alignment and cross-agency benefits.

CMS's internal e-Government plan includes government-to-citizen (G2C), -business (G2B), and -government (G2G) activities focused on developing a culture of responsiveness. Major work has been initiated and in many cases completed for internal e-gov activities, such as: improved customer service relationship management through expanded 1-800-MEDICARE call center services (G2C); expanded and enhanced general web services improving national coverage decision making (G2C), improved access to R&D information (G2B), use of the web for collecting information and improving provider relations (G2B); using electronic rule making and on-line policy manuals (G2B); establishing various electronic State plan and enforcement tracking systems (G2G); and joining with other HHS operating divisions in using a central grant-making common portal for pre- and post-grant award work (G2G). Many of these local initiatives contribute to, or draw from, the 24 PMA initiatives.

BUDGET AND PERFORMANCE INTEGRATION

CMS's Annual Performance Plan (APP) complements and supports the agency's FY 2004 budget request and is integral to it. Our FY 2004 and revised FY 2003 APPs and our FY 2002 Annual Performance Report are attached at Tab VI.

CMS has taken care to ensure that major budget categories, including both program benefits and program administration funds, have adequate coverage in the APP. The CMS performance plan and report are organized by budget category to provide a linkage of performance goals, program activities, and dollar amounts. These linkages ensure that, in setting performance goals, CMS selects goals that are representative of the full range of agency activities and resources.

Beginning in FY 2004, agency budgets will focus on results-oriented government guided by performance. The Office of Management and Budget developed the Program Assessment Rating Tool (PART) to evaluate programs in a systematic and objective manner, using numeric scores which rate overall program effectiveness and highlight strengths and weaknesses. In 2002, two of CMS's programs, the Medicare Integrity Program (MIP) and the State Children's Health Insurance Program (SCHIP), were assessed using the PART. Both programs received high scores. As a result of the PART process, CMS has included in its FY 2004 APP two new program integrity goals measuring the Medicare contractor error rate and provider compliance rate.

CMS's overall number of goals has remained relatively stable. CMS has increased the proportion of outcome-oriented goals that speak to fundamental program purposes and to the agency's role as a steward of taxpayer dollars. The total number of FY 2004 goals in the APP is 37, with reporting on 35 FY 2002 goals.

Section V Contents

SUPPORTING INFORMATION

Program Management

Table V-1	Amounts Available for Obligation	V-1
Table V-2	Summary of Changes.....	V-2
Table V-3	Budget Authority by Activity.....	V-3
Table V-4	Budget Authority by Object - 2 Year.....	V-4
Table V-5	Salaries and Expenses.....	V-6
Table V-6	Appropriations History Table.....	V-7
Table V-7	Authorizing Legislation.....	V-8
Table V-8	Detail of Full-Time Equivalent Employment.....	V-9
Table V-9	Detail of Positions	V-10
Table V-10	Voluntary and Involuntary Terminations	V-11
Table V-11	Change in Configuration	V-12

Grants to States for Medicaid

Table V-12	Summary of Changes.....	V-13
Table V-13	Authorizing Legislation.....	V-14
Table V-14	Appropriations History Table.....	V-15
Table V-15	Medicaid Requirements.....	V-16
Table V-16	Budget Authority by Object.....	V-17
Table V-17	Amounts Available for Obligation	V-18
Table V-18	Adjusted State Estimates	V-19
Table V-19	Estimates of Grant Awards.....	V-20
Table V-20	Proposed Law	V-22
Table V-21	Vaccines for Children Program	V-23

Other

Information Technology	V-25
Medicare Benefits	V-31
Clinical Laboratory Improvement Amendments of 1988	V-33
Audited Financial Statement.....	V-37
Health Care Fraud and Abuse Control.....	V-39
State Grants and Demonstrations.....	V-49

Section V Contents, Continued

National <i>Medicare & You</i> Education Program	V-53
State Children's Health Insurance Program	V-59
Significant Items	V-65
Benefits Improvement and Protection Act.....	V-73

SUPPORTING INFORMATION

PROGRAM MANAGEMENT
Table V-1 Amounts Available for Obligation
CURRENT LAW

	2002 Actual	2003 President's Budget 1/	2004 Estimate
Appropriation, Comparable	\$2,513,798,000	\$2,586,628,000	\$2,733,507,000
Comparable Transfer (Appeals)	-73,000,000	-73,000,000	0
Subtotal, Appropriation	\$2,440,798,000	\$2,513,628,000	\$2,733,507,000
Enacted Rescissions P.L. 107-116/206	-8,027,000	0	0
Subtotal, Net Appropriation/B.A.	\$2,432,771,000	\$2,513,628,000	\$2,733,507,000
Offsetting Collections			
HMO User Fees	0	153,000	0
Sale of Data User Fees	2,260,000	2,013,000	2,047,000
CLIA User Fees	43,731,000	43,000,000	43,000,000
Medicare+Choice User Fees	14,497,000	16,000,000	14,000,000
Reimbursables	5,287,000	0	0
Subtotal, Offsetting Collections	\$65,775,000	\$61,166,000	\$59,047,000
Program Level, Current Law	\$2,498,546,000	\$2,574,794,000	\$2,792,554,000
Unobligated Balance, Start of Year 2/	80,034,000	99,134,000	65,648,000
Change in Prior Year Offsetting Collections	-864,000	0	0
Unobligated Balance Lapsing	-4,382,000	0	0
Prior Year Recoveries	30,761,000	0	0
Unobligated Balance, End of Year 2/	-99,134,000	-65,648,000	-65,648,000
Total Obligations, Current Law	\$2,504,961,000	\$2,608,280,000	\$2,792,554,000

1/ This column reflects the current estimate for FY 2003. The FY 2003 President's budget requested \$2,538,330,000 as the Program Management appropriation.

2/ In FY 2003, CMS has available for obligation the remaining \$33.5 million of no-year funds included in CMS's FY 1998, FY 2000, FY 2001 and FY 2002 appropriations for the transition to a single Part A and Part B processing system and managed care redesign activities.

PROPOSED LAW (P.L.)

Appropriation	\$0	\$0	-\$201,000,000
Proposed Program Management User Fees	0	0	201,000,000
Subtotal, Program Level, Net P.L.	0	0	0
Appropriation, Net P.L.	0	0	2,532,507,000
Total User Fees, Net P.L.	0	0	260,047,000
Total, Program Level, Net. P.L.	\$0	\$0	\$2,792,554,000

SUPPORTING INFORMATION

PROGRAM MANAGEMENT

Table V-2 Summary of Changes

FY 2003 President's Budget, Comparable 1/ 2/.....				\$2,586,628,000
FY 2004 Estimate.....				\$2,733,507,000
Net Change 1/.....				\$146,879,000
Increases:				
	2003 Pres. Bgt. Base		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
A. Built-in				
1. One quarter of FY 2003				
Pay Raise				\$3,183,000
2. Three quarters impact of FY 2004				
Pay Raise				\$6,161,000
3. Increase in Personnel Benefits				\$1,103,000
4. Promotion/Career Ladder				
Increases				\$6,073,000
5. Day of Extra Pay				\$1,573,000
Subtotal, Built-in Increases				<u>\$18,093,000</u>
B. Program				
1. Medicare Operations	0	\$1,748,084,000	10	\$177,585,000
2. Federal Administration		\$562,497,000		\$20,402,000
3. Research		\$28,400,000		\$41,000,000
4. Revitalization Plan		\$0		\$65,000,000
Subtotal, Program Increases				<u>\$303,987,000</u>
Total Increases				<u>\$322,080,000</u>
Decreases:				
A. Built-in				
1. Awards and Overtime				(\$1,293,000)
Subtotal, Built-in Decreases				<u>(\$1,293,000)</u>
B. Program				
1. Medicare Operations		\$1,748,084,000		(\$148,780,000)
2. Federal Administration	4,581	\$562,497,000	(183)	(\$19,128,000)
3. Research		\$28,400,000		(\$6,000,000)
Subtotal, Program Decreases				<u>(\$173,908,000)</u>
Total Decreases				<u>(\$175,201,000)</u>
Net Change, Appropriation, Current Law				<u>\$146,879,000</u>
Offsetting Collections:				
CLIA User Fee	80	\$43,000,000	(2)	\$0
HMO User Fee		\$153,000		(\$153,000)
Sale of Dam User Fee		\$2,013,000		\$34,000
Medicare+Choice User Fee		\$16,000,000		(\$2,000,000)
Subtotal, Offsetting Collections				<u>(\$2,119,000)</u>
Net Change, Total Program Level, Current Law				<u>\$144,760,000</u>

1/ Both the FY 2003 President's budget and the net change are calculated on a comparable basis. The FY 2003 base includes a \$73.0 million comparability adjustment for the costs of processing Medicare appeals pursuant to BIPA section 521.

2/ This column reflects the current estimate for FY 2003. Appropriated funds in the FY 2003 President's budget were \$2,538,330,000. The FY 2003 FTE count also reflects our current estimate. The estimate in the President's budget totalled 4,476 FTEs.

SUPPORTING INFORMATION

PROGRAM MANAGEMENT
Table V-3 Budget Authority by Activity
(dollars in thousands)

Activity	2003					
	2002		President's		2004	
	Actual 1/		Budget 2/		Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Medicare Operations		\$1,534,500		\$1,675,084		\$1,776,889
Comparability Adjustment (Appeals) 3/		\$73,000		\$73,000		\$0
Enacted Rescission (P.L. 107-116/206)		(\$2,500)		\$0		\$0
Subtotal, Medicare Operations		\$1,605,000		\$1,748,084		\$1,776,889
(Obligations) 3/	0	(\$1,521,369)	0	(\$1,781,570)	10	(\$1,776,889)
2. Federal Administration		\$531,700		\$562,497		\$580,571
Enacted Rescission (P.L. 107-116/206)		(\$1,215)		\$0		\$0
Subtotal, Federal Administration		\$530,485		\$562,497		\$580,571
(Obligations)	4,417	(\$530,405)	4,581	(\$562,497)	4,398	(\$580,571)
3. State Survey & Certification		\$256,397		\$247,647		\$247,647
Enacted Rescission (P.L. 107-116/206)		(\$3,312)		\$0		\$0
Subtotal, State Survey & Cert.		\$253,085		\$247,647		\$247,647
(Obligations)		(\$252,500)		(\$247,647)		(\$247,647)
4. Research, Demonstration & Evaluation		\$118,201		\$28,400		\$63,400
Enacted Rescission (P.L. 107-116/206)		(\$1,000)		\$0		\$0
Subtotal, Research		\$117,201		\$28,400		\$63,400
(Obligations)		(\$117,034)		(\$28,400)		(\$63,400)
5. Revitalization Plan		\$0		\$0		\$65,000
Subtotal, Revitalization Plan		\$0		\$0		\$65,000
(Obligations)		\$0		\$0		(\$65,000)
Total Approp./Budget Auth.		\$2,505,771		\$2,586,628		\$2,733,507
Subtotal Obligations 4/	4,417	(\$2,421,308)	4,581	(\$2,620,114)	4,408	(\$2,733,507)
Offsetting Collections: Current Law						
Program Management User Fees		\$60,488		\$61,166		\$59,047
(Obligations)	80	(\$78,366)	80	(\$61,166)	78	(\$59,047)
Other Reimbursables		\$5,287		\$0		\$0
(Obligations)		(\$5,287)		\$0		\$0
Program Level, Current Law		\$2,571,546		\$2,647,794		\$2,792,554
Total Obligations 4/	4,497	(\$2,504,961)	4,661	(\$2,681,280)	4,486	(\$2,792,554)

1/ The FY 2002 actual column reflects final (net) appropriation after all rescissions, transfers and reprogrammings. The FY 2002 actual column also reflects actual year-end FTE consumption.

2/ This column reflects the current estimate for FY 2003. Appropriated funds in the FY 2003 President's budget were \$2,538,330,000. The FY 2003 FTE count also reflects our current estimate. Our estimate in the President's budget totalled 4,476 FTE's.

3/ Fiscal years 2002 and 2003 contain a \$73.0 million comparability adjustment related to the processing of Medicare appeals (BIPA sec. 521). The projected FY 2003 Medicare Operations obligations displayed above has also been comparably adjusted (+\$73.0 million).

4/ In FY 2003, the CMS has available to obligate the remaining \$33.5 million of no-year funds included in our FY 1998, FY 2000, FY 2001 and FY 2002 appropriations for the transition to a single Part A and Part B processing system and managed care redesign activities.

SUPPORTING INFORMATION

PROGRAM MANAGEMENT

Table V-4 Budget Authority by Object - 2 Year

	2003 President's Budget 1/	2004 Estimate	Increase or Decrease
Total number of full-time permanent positions 2/	4,581	4,408	(173)
Average ES salary	\$124,418	\$127,248	\$2,830
Average GS grade	12.9	12.9	-
Average GS salary	\$73,141	\$74,805	\$1,664
Average salary of ungraded positions	\$80,767	\$82,604	\$1,837
Personnel Compensation:			
Full-time Permanent	\$337,100,000	\$337,859,000	\$759,000
Other than Full-time Permanent	9,869,000	10,449,000	580,000
Other Personnel Compensation	4,890,000	3,597,000	(1,293,000)
Military Personnel	7,436,000	7,613,000	177,000
Personnel Benefits	72,266,000	73,652,000	1,386,000
Military Personnel Benefits	2,338,000	2,632,000	294,000
Subtotal, Pay Costs, Current Law	\$433,899,000	\$435,802,000	\$1,903,000

1/ This column reflects the current estimate for FY 2003.

2/ Does not include 80 reimbursable FTEs in FY 2003 and 78 reimbursable FTEs in FY 2004.

SUPPORTING INFORMATION

PROGRAM MANAGEMENT

Table V-4 Budget Authority by Object (Continued)

	2003 President's Budget 3/	2004 Estimate	Increase or Decrease
Travel	\$9,500,000	\$10,700,000	\$1,200,000
Transportation of Things	-	-	-
Rent:			
Rental Payments to GSA	16,300,000	16,300,000	-
Communications, Utilities, and Miscellaneous Charges	11,200,000	3,200,000	(8,000,000)
Printing and Reproduction	3,565,000	3,265,000	(300,000)
Advisory and Assistance Services	30,000	30,000	-
Other Services	405,696,000	435,848,000	30,152,000
Purchases of Goods and Services from Government Accounts	2,200,000	2,200,000	-
Medical Care 4/	1,748,084,000	1,833,889,000	85,805,000
Subtotal, Contractual Services, Current Law	2,156,010,000	2,271,967,000	115,957,000
Supplies and Materials	1,420,000	1,420,000	-
Equipment	100,000	100,000	-
Land and Structures	9,800,000	9,800,000	-
Grants, Subsidies, and Contributions	6,000,000	40,000,000	34,000,000
Total Non-Pay Costs, Current Law	\$2,213,895,000	\$2,356,752,000	\$142,857,000
Total Budget Authority, Current Law	\$2,647,794,000	\$2,792,554,000	\$144,760,000

3/ This column reflects the current estimate for FY 2003.

4/ In FY 2003, the medical care line includes a \$73.0 million comparability adjustment relating to Medicare appeals activities (BIPA sec. 521).

SUPPORTING INFORMATION

PROGRAM MANAGEMENT
Table V-5 Salaries and Expenses

Activity	2003 President's Budget 1/	2004 Estimate	Increase or Decrease
Personnel Compensation:			
Full-time permanent (11.1)	\$337,100,000	\$337,859,000	\$759,000
Other than Full-Time Permanent (11.3)	9,869,000	10,449,000	580,000
Other Personnel Compensation (11.5/11.8)	4,890,000	3,597,000	(1,293,000)
Military Personnel (11.7)	7,436,000	7,613,000	177,000
Total Pers. Compensation (11.9)	\$ 359,295,000	\$ 359,518,000	\$ 223,000
Civilian Personnel Benefits (12.1)	72,266,000	73,652,000	1,386,000
Military Personnel Benefits (12.2)	2,338,000	2,632,000	294,000
Subtotal Pay Costs	\$ 433,899,000	\$ 435,802,000	\$ 1,903,000
Travel (21.0)	9,500,000	10,700,000	1,200,000
Transportation of Things (22.0)	-	-	-
Communications, Utilities, and Miscellaneous Charges (23.3)	11,200,000	3,200,000	(8,000,000)
Printing and Reproduction (24.0)	3,565,000	3,265,000	(300,000)
Other Contractual Services:			
Advisory and Assistance Services (25.1)	30,000	30,000	-
Other Services (25.2)	405,696,000	435,848,000	30,152,000
Purchases of Goods and Services from Government Accounts (25.3)	2,200,000	2,200,000	-
Medical Care (25.6) 2/	1,748,084,000	1,833,889,000	85,805,000
Subtotal Other Contractual Svcs.	\$ 2,156,010,000	\$ 2,271,967,000	\$ 115,957,000
Supplies and Materials (26.0)	1,420,000	1,420,000	-
Subtotal Non-Pay Costs	\$ 2,181,695,000	\$ 2,290,552,000	\$ 108,857,000
Total Salaries and Expenses	\$ 2,615,594,000	\$ 2,726,354,000	\$ 110,760,000

1/ This column reflects the current estimate for FY 2003.

2/ In FY 2003, the medical care line includes a \$73.0 million comparability adjustment relating to Medicare appeals activities (BIFA sec. 521).

SUPPORTING INFORMATION

PROGRAM MANAGEMENT
Table V-6 Appropriations History Table

Year	Budget Est. to Congress	House Allowance	Senate Allowance	Appropriation
1995	--	--	--	--
Trust Fund Transfer	2,191,800,000	2,183,985,000	2,207,237,000	2,207,135,000
Reduction	--	--	--	-8,391,000
Rescission	--	--	--	-20,596,000
1996	--	--	--	--
Trust Fund Transfer	2,253,794,000	2,130,810,000	2,111,406,000	2,130,810,000
Reduction	--	--	--	-6,529,000
1997	--	--	--	1/
Trust Fund Transfer	2,202,284,000	1,733,125,000	1,729,584,000	1,735,125,000
Reduction	--	--	--	-684,000
Transfer	--	--	--	-2,000,000 2/
1998	--	--	--	--
Trust Fund Transfer	1,774,500,000	1,679,435,000	1,719,241,000	1,743,066,000 3/
Supplemental Approp.	--	--	--	2,200,000
Transfer	--	--	--	43,641,000
1999	--	--	--	--
Trust Fund Transfer	1,678,000,000	1,942,500,000	1,685,550,000	1,946,500,000
Supplemental Approp.	--	--	--	174,200,000 4/
2000	--	--	--	--
Trust Fund Transfer	2,016,126,000	1,752,050,000	1,991,321,000	1,994,548,000
Rescission	--	--	--	-1,214,000
Transfer	--	--	--	2,992,000 5/
2001	--	--	--	--
Trust Fund Transfer	2,086,302,000	1,866,302,000	2,018,500,000	2,246,326,000
Rescission	--	--	--	-4,164,000 6/
Transfer	--	--	--	-564,000
2002	--	--	--	--
Trust Fund Transfer	2,351,158,000	2,361,158,000	2,464,658,000	2,440,798,000
Rescission	--	--	--	-8,027,000 6/
2003	--	--	--	--
Trust Fund Transfer	2,538,330,000	2,550,488,000	2,559,664,000	-- 7/
2004	--	--	--	--
Trust Fund Transfer	2,733,507,000	--	--	--

1/ Beginning in FY 1997, under P.L. 104-191, the Medicare Integrity Program (MIP) funds payment safeguard activities from a mandatory program under the Hospital Insurance (HI) Trust Fund.

2/ Transfer funds to the Administration on Aging to implement a demonstration project to train retirees as educators in Medicare fraud.

3/ FY 1998 funding included a supplemental appropriation of \$2.2 million for HIPAA implementation and a \$43.641 million transfer from DHHS for contractor millennium conversions and extension of telemedicine demonstrations (Research).

4/ CMS received \$174.2 million in general funds under the government-wide FY 1999 emergency supplemental for Y2K.

5/ Net DHHS transfer for ICFs/MR, less CMS's allocation for Government-wide CIO/CFO councils.

6/ CMS's allocation of the Labor/HHS/Education rescission from administrative expenses.

7/ The FY 2003 appropriation bill had not been enacted at the time the FY 2004 President's budget was being prepared. The FY 2003 House and Senate Allowance columns reflect the latest information available at the time of preparation (House: H.R. 246; Senate: S.A. 19, H.J. Res. 2).

SUPPORTING INFORMATION

PROGRAM MANAGEMENT
Table V-7 Authorizing Legislation

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Budget Request
Program Management:				
1. Research:				
a) Social Security Act, Title XI,				
- Section 1110	Indefinite	Indefinite	Indefinite	Indefinite
- Section 1115 1/	\$2,200,000	\$2,200,000	\$2,200,000	\$2,200,000
b) P.L. 92-603, Section 222	Indefinite	Indefinite	Indefinite	Indefinite
2. Medicare Operations:				
Social Security Act, Sections 1816 & 1842	Indefinite	Indefinite	Indefinite	Indefinite
3. State Certification:				
Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs:				
Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
6. Medicare+Choice:				
Balanced Budget Act of 1997, Section 1857 (e)(2)	--	--	--	--
7. Medicare+Choice:				
Balanced Budget Refinement Act of 1999	2/	2/	2/	2/
Total appropriation	--	--	--	--
Total appropriation against definite authority	--	--	--	--

1/ The total authorization for section 1115 is \$4.0 million. CMS's portion of this amount is \$2.2 million.

2/ The Balanced Budget Refinement Act of 1999 limits authorized user fees to an amount computed using a statutory formula based on the ratio of Medicare managed care enrollees to the total Medicare population.

SUPPORTING INFORMATION

PROGRAM MANAGEMENT

TABLE V-8 Detail Of Direct Full-Time Equivalent (FTE) Employment

COMPONENT	FY 2002	FY 2003	FY 2004
	<u>Actual</u>	<u>President's Budget</u>	<u>Estimate</u>
Office of the Administrator.....	25	26	25
Office of Operations Management.....	35	36	35
Office of Public Affairs.....	16	17	18
Office of Legislation.....	44	46	48
Office of Equal Opportunity and Civil Rights.....	21	22	21
Office of Research, Development & Info.....	106	110	106
Office of the Actuary.....	67	69	66
Office of Clinical Standards and Quality.....	143	148	142
Office of Strategic Operations and Reg. Affairs	151	157	151
Center for Beneficiary Choices.....	448	464	447
Center for Medicare Management.....	408	423	407
Center for Medicaid and State Operations.....	396	410	395
Office of Internal Customer Support.....	321	333	320
Office of Information Services.....	409	424	408
Office of Financial Management.....	305	316	304
Office of Hearings.....	32	33	32
HIGLAS	19	20	19
Consortia.....	<u>1,551</u>	<u>1,607</u>	<u>1,542</u>
Total, CMS.....	4,497	4,661	4,486

Average GS Grade

2000.....	12.8
2001.....	12.9
2002.....	12.9
2003.....	12.9
2004.....	12.9

SUPPORTING INFORMATION

PROGRAM MANAGEMENT

Table V-9 Detail of Positions

	2002 <u>Actual</u>	2003 President's <u>Budget</u>	2004 <u>Estimate</u>
Executive Level I.....			
Executive Level II.....			
Executive Level III.....			
Executive Level IV.....	1	1	1
Executive Level V.....			
Subtotal.....	1	1	1
Total - Executive Level Salary.....	\$130,000	\$134,000	\$134,000
ES-6.....	6	6	6
ES-5.....	8	8	8
ES-4.....	10	10	10
ES-3.....	4	4	4
ES-2.....	5	5	5
ES-1.....	12	12	12
Subtotal.....	45	45	45
Total - ES Salary.....	\$5,471,574	\$5,598,788	\$5,726,160
GS-14/15.....	825	831	800
GS-13.....	1,873	1,887	1,816
GS-12.....	1,034	1,042	1,003
GS-11.....	141	142	137
GS-10.....	1	1	1
GS-9.....	207	209	201
GS-8.....	28	28	27
GS-7.....	235	237	228
GS-6.....	71	72	69
GS-5.....	54	54	52
GS-4.....	39	39	38
GS-3.....	10	10	10
GS-2.....	10	10	10
GS-1.....	1	1	1
Subtotal.....	4,529	4,563	4,393
Total staffing, end of year.....	4,626	4,661	4,486
Direct FTE's.....	4,417	4,581	4,408
Reimbursable FTE's.....	80	80	78
Total full-time equivalent usage.....	4,497	4,661	4,486
	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
Average ES level.....	3.3	3.3	3.3
Average ES salary.....	\$121,591	\$124,418	\$127,248
Average GS/GM grade.....	12.9	12.9	12.9
Average GS/GM salary.....	\$70,942	\$73,141	\$74,805

SUPPORTING INFORMATION

MEDICARE & MEDICAID STATE CERTIFICATION									
V-10 Voluntary and Involuntary Terminations									
Facility Type	FY 2000			FY 2001			FY 2002		
	VOL.	INVOL.	TOTAL	VOL.	INVOL.	TOTAL	VOL.	INVOL.	TOTAL
Skilled Nursing Facilities	275	21	296	243	26	269	218	11	229
Nursing Facilities	47	8	55	52	2	54	27	1	28
Intermediate Care Facilities for the Mentally Retarded	73	13	86	67	13	80	80	4	84
Hospitals	144	3	147	98	2	100	106	4	110
Home Health Agencies	753	37	790	284	16	300	166	19	185
Hospices	85	7	92	44	2	46	36	2	38
Outpatient Physical Therapy	173	2	175	141	3	144	93	3	96
Comprehensive Outpatient Rehabilitation Facilities	70	1	71	53	1	54	47	1	48
X-Ray	19	0	19	36	0	36	35	0	35
End-Stage Renal Disease Facilities	48	0	48	35	1	36	67	1	68
Rural Health Clinics	217	1	218	158	1	159	142	0	142
Ambulatory Surgical Centers	40	1	41	42	1	43	49	2	51
Total	1,944	94	2,038	1,253	68	1,321	1,066	48	1,114
Note: (Voluntary terminations include mergers, closures, and voluntary withdrawals.) (SNFS are T18 facilities plus Title 18/19 facilities)									

SUPPORTING INFORMATION

MEDICARE OPERATIONS

Table V-11 Change in Configuration of Medicare Contractors

	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>
<u>INTERMEDIARIES 1/</u>							
Blue Cross Plans	37	35	33	30	27	26	25
Commercials/Independents	5	4	4	3	2	2	2
Blue Cross Association	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>
Total Intermediaries	43	40	38	34	30	29	28
<u>CARRIERS 2/</u>							
Blue Shield Plans	19	17	16	15	15	15	15
Commercials/Independents	<u>8</u>	<u>8</u>	<u>7</u>	<u>7</u>	<u>5</u>	<u>5</u>	<u>4</u>
Total Carriers	27	25	23	22	20	20	19
<u>DMERCS 3/</u>							
	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>	<u>4</u>
<u>TOTAL</u>	74	69	65	60	54	53	51

1/ Intermediaries process Part A claims.

2/ Carriers process Part B claims.

3/ Durable Medical Equipment Regional Carriers (DMERCs) process claims/bills for medical supplies and equipment.

SUPPORTING INFORMATION

MEDICAID PROGRAM
Table V-12 Summary of Changes
\$ in Thousands

2003 Budget Authority	\$158,692,155
2004 Estimated Appropriated Budget Authority	\$176,753,583
Net Change	\$18,061,428

Explanation of Changes

	2003 Current Base Budget Authority	Change From Base Budget Authority
Program Increases:		
1. Medical Assistance Payments	\$152,900,000	\$14,500,000
2. State Administration	8,203,284	145,773
3. Fraud Control Units	120,300	4,500
4. State Certification	228,582	14,238
5. Offsetting Collections From Medicare	-127,000	127,000
6. State and Local Administration Financial Adj.	-73,242	429,826
7. Unobligated balance, start of year	-6,893	6,893
8. Estimated Indefinite Authority Requirement	<u>-3,666,956</u>	<u>3,666,956</u>
Total program increases	\$157,578,075	\$18,895,186
Program Decreases:		
1. Vaccine Purchase	1,056,185	-75,989
2. HIPAA Admin. Simplification Reg. (ADM)	423,058	-428,999
3. CR TMA Adjustment	175,000	-175,000
4. Disallowances for Prohibited Provider Taxes	-233,163	-124,770
5. Financial Management Reviews	<u>-307,000</u>	<u>-29,000</u>
Total program decreases	1,114,080	-833,758
TOTAL	\$158,692,155	\$18,061,428

SUPPORTING INFORMATION

MEDICAID PROGRAM

Table V-13 Authorizing Legislation

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Budget Request
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	\$157,868,217,000	Indefinite	\$175,773,387,000
Vaccines for Childrens Program (Social Security Act, title XIX, Section 1928)		<u>\$823,938,000</u>		<u>\$980,196,000</u>
Total appropriations		\$158,692,155,000		\$176,753,583,000

SUPPORTING INFORMATION

MEDICAID PROGRAM

Table V-14 Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1994	89,060,413,000	89,077,413,000	89,077,413,000	89,077,413,000
1995	89,237,775,000	89,237,775,000		89,240,775,000
1996	82,142,072,000	82,142,072,000	82,142,072,000	82,142,072,000
1997	101,192,815,000	101,211,968,000	101,211,968,000	101,211,968,000
1998	99,519,422,000	99,519,422,000	99,591,422,000	99,591,422,000
1999	102,394,422,000	102,394,422,000	102,394,422,000	102,394,422,000
2000	114,820,998,000	114,820,998,000	114,820,998,000	117,744,046,209 ^{1/}
2001	124,175,254,000	124,175,254,000	124,175,254,000	129,418,807,224 ^{2/}
2002	143,029,433,000	143,029,433,000	143,029,433,000	147,340,339,015 ^{3/}
2003	158,692,155,000	^{4/}	158,692,155,000	^{5/}
2004	176,753,583,000			

^{1/} Includes \$2,923.0 million under indefinite authority.

^{2/} Includes \$5,243.6 million under indefinite authority.

^{3/} Includes \$4,310.9 million under indefinite authority.

^{4/} An allowance for FY 2003 has not been approved.

^{5/} An appropriation for FY 2003 has not been approved.

SUPPORTING INFORMATION

MEDICAID PROGRAM
Table V-15 Medicaid Requirements
(dollars in thousands)

	2003 Estimate	2004 Estimate
November 2002 State Estimates (MAP & ADM)	\$159,094,952	\$169,489,972
State Certification	228,582	242,820
Fraud Control Units	120,300	124,800
Total, unadjusted estimates	\$159,443,834	\$169,857,592
Adjustments		
Financial Management Reviews	-307,000	-336,000
Financial Adjustments for Admin. Costs	-73,242	356,584
Continuing Resolution Transitional Medical Assistance	175,000	0
Disallowances for Prohibited Provider Taxes	-233,163	-357,933
Actuarial Adjustments for State Estimates	2,008,332	6,259,085
Adjustments for Medicare Part B transfer		
HIPAA Privacy & Admin. Simplification Reg.	423,058	-5,941
Subtotal, Adjustments	\$1,992,985	\$5,915,795
Vaccines For Children Program	\$1,056,185	\$980,196
Current law requirement	\$162,493,004	\$176,753,583
Unobligated Balances,		
Start of year	-6,893	0
End of year	0	0
Gross Budget Authority	\$162,486,111	\$176,753,583
Offsetting Collections	-127,000	0
Appropriation/ net budget authority	\$162,359,111	\$176,753,583

SUPPORTING INFORMATION

MEDICAID PROGRAM

Table V-16 Budget Authority by Object

	2003 Estimate	2004 Estimate	Increase or Decrease
<u>CMS - GRANTS TO STATES</u>			
Grants to States, Subsidies, and Contributions	\$161,429,926,000	\$175,773,387,000	\$14,343,461,000
<u>CDC - VACCINES FOR CHILDREN</u>			
Utilities, Rent, and Program Support Activities	\$10,525,000	\$9,807,000	-\$718,000
Intramural Research and Program Assistance	\$5,284,000	\$5,416,000	\$132,000
Grants/Cooperative Agreements and Research Contracts	<u>\$1,040,376,000</u>	<u>\$964,973,000</u>	-\$75,403,000
Total budget authority	\$162,486,111,000	\$176,753,583,000	\$14,267,472,000

SUPPORTING INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services
Appropriation
Medicaid Program

Table V-17 Amounts Available for Obligation
(dollars in thousands)

	2002 Actual	2003 Estimate	2004 Estimate
Appropriation: Annual	\$143,029,433	\$158,692,155	\$176,753,583
Appropriation: Indefinite.....	4,310,906	0	0
Unobligated balance, start of year	110,021	6,893	0
Unobligated balance, end of year	-6,893	0	0
Recoveries of Prior Year Obligations	4,198,147	0	0
Offsetting Collections	137,917	127,000	0
Change in Receivables	-135,823		
Estimated Request for Indefinite Authority	0	3,666,956	0
Total Gross Obligations	\$151,643,708	\$162,493,004	\$176,753,583
Medicare Part B Transfer		-\$50,000	
Total Net Obligations	\$151,643,708	\$162,443,004	\$176,753,583

SUPPORTING INFORMATION

MEDICAID

(State Submitted Estimates with Actuary Adjustments)

Table V-18 MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE CATEGORY
(dollars in thousands)

	FY 2003		FY 2004	
	Amount	%	Amount	%
Nursing Facility	26,860,049	17.80%	27,823,066	17.27%
Insurance Payments/MCO's	21,823,755	14.46%	24,120,952	14.97%
Prescribed Drugs	19,055,444	12.63%	21,552,781	13.38%
Inpatient Hospital / Regular Payment	18,181,305	12.05%	19,165,589	11.89%
HCBS/Regular	10,740,747	7.12%	11,241,987	6.98%
Inpatient Hospital / DSH Adj. Payment	7,239,790	4.80%	6,712,525	4.17%
Outpatient Hospital	5,723,499	3.79%	6,259,659	3.88%
All Other	5,853,803	3.88%	6,239,209	3.87%
Physicians	4,817,210	3.19%	5,243,879	3.25%
ICF/MR - Public	4,035,420	2.67%	4,215,836	2.62%
Personal Care	3,569,926	2.37%	4,011,544	2.49%
Clinic	3,672,507	2.43%	3,942,536	2.45%
Medicaid Health Insurance/Other	2,911,167	1.93%	3,037,941	1.89%
ICF/MR - Private	2,636,070	1.75%	2,787,086	1.73%
Mental Health Facility / Regular Payment	2,586,039	1.71%	2,724,101	1.69%
Medicare Health Ins. Pymts./ Part B Premiums	2,230,562	1.48%	2,389,776	1.48%
Home Health	1,685,726	1.12%	1,854,360	1.15%
Dental	1,670,371	1.11%	1,828,345	1.13%
Mental Health Facility / DSH Adj. Payment	1,653,854	1.10%	1,649,844	1.02%
Targeted Case Management Services	1,539,367	1.02%	1,643,344	1.02%
Medicaid Health Ins./Prepaid Health Plan	1,361,005	0.90%	1,530,473	0.95%
Other Practitioners	947,059	0.63%	1,033,356	0.64%
Medicare Health Ins. Pymts./ Part A Premiums	870,848	0.58%	913,383	0.57%
Emergency Services Undocumented Aliens*	860,141	0.57%	898,525	0.56%
EPSDT Screenings	624,499	0.41%	666,443	0.41%
Federally-Qualified Health Centers	539,115	0.36%	574,999	0.36%
Lab/Radiological	520,460	0.34%	562,337	0.35%
Hospice Benefits	430,770	0.29%	489,839	0.30%
Medicare Health Insurance/Coins. & Deduct.	293,234	0.19%	309,029	0.19%
Rural Health Clinic	247,541	0.16%	283,690	0.18%
Primary Care Case Management Services	118,893	0.08%	201,262	0.12%
HCBS/Frail Elderly	142,260	0.09%	162,379	0.10%
Sterilizations	103,356	0.07%	116,420	0.07%
Medicaid Group Health Plan Premiums	67,082	0.04%	78,817	0.05%
Programs of All-Inclusive Care for Elderly**	43,627	0.03%	44,343	0.03%
Medicaid Group Health Plan Coins. & Deduct.	13,202	0.01%	13,523	0.01%
Abortions	84	0.00%	83	0.00%
Drug Rebate / State Agreement	(172,497)	-0.11%	(189,813)	-0.12%
Collections/Adjustments	(1,030,030)	-0.68%	(1,100,802)	-0.68%
Drug Rebate / National Agreement	(3,575,592)	-2.37%	(3,891,731)	-2.42%
Total State Submitted Estimates	\$150,891,668	100.00%	\$161,140,915	100.00%
Actuary Adjustments	2,008,332		6,259,085	
Total	\$152,900,000		\$167,400,000	

* Estimates from reporting prior allotment states

** Estimates of costs provided as an optional service (not under a Section 1115 waiver)

SUPPORTING INFORMATION

STATE TABLES

Table V-19 Estimates of Grant Awards
(dollars in thousands)

	FY 2002 Obligations	FY 2003 Estimate	FY 2004 Estimate
Alabama	\$2,284,697	\$2,297,147	\$2,498,116
Alaska	499,595	507,510	536,791
American Samoa	3,470	3,620	3,620
Arizona	2,515,859	3,089,898	3,403,630
Arkansas	1,778,650	1,808,276	1,883,376
California	15,417,626	16,400,909	16,773,353
Colorado	1,237,013	1,370,232	1,405,367
Connecticut	1,837,157	1,933,523	2,084,309
Delaware	377,151	360,699	366,955
District of Columbia	810,501	854,953	871,268
Florida	5,866,161	6,766,407	7,078,372
Georgia	4,223,853	3,983,295	4,395,505
Guam	5,921	6,140	6,140
Hawaii	464,772	489,685	513,883
Idaho	607,783	623,802	661,073
Illinois	4,853,987	4,892,698	5,608,260
Indiana	2,773,571	3,049,143	3,387,938
Iowa	1,686,563	1,463,788	1,559,921
Kansas	1,202,605	1,102,614	1,085,101
Kentucky	2,812,262	2,774,057	2,786,240
Louisiana	3,563,060	3,538,119	3,735,081
Maine	1,019,628	1,077,046	1,195,081
Maryland	1,937,056	2,126,757	2,340,933
Massachusetts	4,155,775	4,583,898	4,747,040
Michigan	5,072,834	4,713,285	4,747,131
Minnesota	2,396,953	2,645,333	2,896,950
Mississippi	2,254,686	2,443,130	2,631,793
Missouri	3,552,986	3,469,346	3,832,278
Montana	471,087	462,179	492,666
Nebraska	858,883	866,216	931,792
Nevada	462,175	554,267	594,705
New Hampshire	519,739	588,979	612,505
New Jersey	4,181,342	4,171,695	4,358,495
New Mexico	1,365,092	1,465,738	1,572,677

SUPPORTING INFORMATION

STATE TABLES

Table V-19 Estimates of Grant Awards (cont.)
(dollars in thousands)

	FY 2002 Obligations	FY 2003 Estimate	FY 2004 Estimate
New York	18,339,659	21,542,393	23,674,744
North Carolina	4,448,904	4,885,071	5,472,244
North Dakota	340,848	337,314	344,100
Northern Mariana Islands	2,100	2,190	2,190
Ohio	5,919,055	6,450,203	7,142,873
Oklahoma	1,800,676	1,934,385	1,926,119
Oregon	1,680,165	1,894,861	1,968,221
Pennsylvania	7,204,070	7,525,108	7,940,687
Puerto Rico	192,900	201,400	201,400
Rhode Island	812,004	845,238	893,525
South Carolina	2,465,078	2,571,718	2,613,730
South Dakota	386,036	370,263	373,273
Tennessee	4,282,845	4,047,238	4,134,061
Texas	8,705,000	9,485,662	9,935,720
Utah	728,501	776,867	879,874
Vermont	460,758	477,521	502,537
Virginia	2,204,823	2,073,049	2,201,666
Virgin Islands	6,354	6,350	6,350
Washington	2,833,169	2,905,075	3,158,947
West Virginia	1,328,659	1,325,246	1,377,382
Wisconsin	2,782,134	2,757,799	2,939,222
Wyoming	191,046	195,617	202,762
Subtotal /Grants/Unadj. St. Ests	\$150,185,277	\$159,094,952	\$169,489,972
Survey & Certification	178,056	228,582	242,820
Fraud Control Units	116,978	120,300	124,800
Vaccines For Children	982,667	1,056,185	980,196
Adjustments	180,730	1,942,985	5,915,795
Total Net Obligations	\$151,643,708	\$162,443,004	\$176,753,583
Medicare Part B Transfer		50,000	0
Total Gross Obligations	\$151,643,708	\$162,493,004	\$176,753,583

SUPPORTING INFORMATION

MEDICAID AND SCHIP PROGRAMS

Table V-20 Proposed Law

	FY 2003	FY 2004
Medicaid/SCHIP Reform:		
State Health Care Partnership Allotments Option		\$3,258,000,000
Prescription Drug Proposal		-\$800,000,000
Spousal Exemption		\$16,000,000
Repropose FY 2003 New Freedom Initiative Demonstrations		\$8,000,000
"Money Follows the Individual" Re-balancing Demonstration		\$350,000,000
Presumptive Eligibility for Community Based Services		
Pay Nursing Homes Directly for Services to Residents Electing Hospice Care		
Extension of Expiring SCHIP Funds		\$35,000,000
Vaccines for Children Program (VFC)		
VFC - Underinsured Children		\$150,000,000
VFC - Lift Tetanus-Diphtheria Price Cap		\$15,000,000
TMA - Extend and Simplify Transitional Medical Assistance		
TMA Extension	\$175,000,000	\$400,000,000
Statutory Modifications		\$20,000,000
Extension of Premium Assistance for QI-1s	\$50,000,000	\$115,000,000
Special Enrollment Period in the Group Market for Medicaid/SCHIP Eligibles		
Reform Interaction Effect		-\$156,000,000
TOTAL	\$225,000,000	\$3,411,000,000
Related Non-CMS Proposals:		
SSA Disability Determinations		
Mandatory Review/Adjustment of Child Support Orders		
Tax Credits for Health Insurance		

SUPPORTING INFORMATION

MEDICAID PROGRAM
Vaccines for Children Program (CDC)
Table V-21

(dollars in thousands)

	<u>FY 2002 Actual</u>	<u>FY 2003 Request</u>	<u>FY 2004 Request</u>	<u>Change +/-</u>
Intramural Research and Program Assistance	\$5,404	\$5,284	\$5,416	\$132
Extramural Programs: Grants/Cooperative Agreements and Research Contracts	<u>\$968,334</u>	<u>\$1,040,376</u>	<u>\$964,973</u>	<u>-\$75,403</u>
Subtotal Direct	\$973,738	\$1,045,660	\$970,389	-\$75,271
Centralized Utilities, Rent, and Program Support Services	<u>\$8,929</u>	<u>\$10,525</u>	<u>\$9,807</u>	<u>-\$718</u>
Total	\$982,667	\$1,056,185	\$980,196	-\$75,989

SUPPORTING INFORMATION

Information Technology

Budget Estimates

CMS's information technology (IT) budget for FY 2004 is currently estimated at \$527.5 million. Funding for IT projects is spread across several CMS budget accounts. The FY 2004 estimate includes \$410.1 million in the CMS Program Management appropriation, which is the primary focus of this budget submission and the narrative below. This figure excludes basic claims processing costs incurred by contractors in our Medicare operations. The following table shows the IT budget by CMS account:

Funds Source: (dollars in thousands)	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Medicare Operations	\$317,298	\$352,983	\$285,918	-\$67,065
Federal Administration	48,999	48,214	43,695	-4,519
Survey and Certification	16,710	1,017	1,517	+500
Research	14,966	12,400	14,000	+1,600
CMS Revitalization Plan	N/A	N/A	65,000	+65,000
Total, Program Management Approp.	\$397,973	\$414,613	\$410,129	-\$4,484
CLIA (user fees)	1,200	1,685	1,427	-259
HCFAC/Medicare Integrity Program (MIP)	21,424	29,386	33,176	+3,791
Quality Improvement Organizations (QIOs)	51,402	81,600	82,762	+1,162
Total, CMS IT Portfolio 1/ 2/ 3/	\$471,999	\$527,284	\$527,494	+\$210

1/ The IT totals shown above for FYs 2002-2004 include CMS's contribution to two HHS-wide IT funds and therefore exceed the sum of CMS projects appearing on HHS Exhibit 53.

2/ The FY 2003 column of HHS Exhibit 53 reflects the current estimates in CMS Exhibit 300s and therefore no longer ties to the 2003 President's budget as printed (shown above).

3/ In addition to the amounts shown above, the HHS Exhibit 53 includes \$1.8 billion in FY 2004 for the Medicaid Management Information System (MMIS) and other Medicaid-related systems, which are funded separately via the annual Medicaid appropriation and administered by the States.

CMS's budget request includes savings in the IT budget from on-going IT consolidation efforts and additional reduced spending through the streamlining or elimination of lower priority projects.

Highlights of the Budget Estimates

The estimated IT spending included in this budget request is intended to meet basic operational needs and support certain key agency initiatives.

SUPPORTING INFORMATION

Ongoing operations activities in the Medicare Operations portion of the CMS Program Management appropriation include:

- maintenance of Medicare fee-for-service claims processing shared systems;
- support for Medicare fee-for-service data center processing, Medicare managed care systems maintenance, infrastructure and network support including the Medicare data communications network (MDCN) and operations of the Common Working File (CWF);
- continuing transition of Medicare carriers (contractors) to the Part B selected shared system; and
- support for a minimal level of ongoing systems security activities at Medicare contractors.

The Federal Administration portion of the Program Management appropriation provides funding for ongoing CMS operations of CMS infrastructure, including the Consolidated Information Technology Infrastructure Contract (CITIC). Awarded in May 2002, the CITIC contract has already reduced infrastructure expenditures as well as our IT request for FY 2004. CITIC encompasses a variety of IT services, including:

- operation and maintenance of all computer platforms (desktops/servers/mainframe);
- local area network (LAN) services and wide area network (WAN) support;
- CMS central office telephone communications services;
- customer service desk;
- web-casting services; and
- planning for future infrastructure enhancements.

In addition, the Federal Administration request supports web-hosting services, satellite services, data management support, and a minimal level of ongoing systems security activities on the CMS enterprise. This request also funds administrative systems that support grant/contract administration and financial management and a number of Medicaid data systems.

Other ongoing operations funded from the Program Management budget include maintenance of the Online Survey and Certification Report system (OSCAR) and the Medicare Current Beneficiary Survey (MCBS), while user fees under the Clinical Laboratory Improvement Amendments (CLIA) fund systems that support that program.

IT funding from the permanently appropriated Medicare Integrity Program (MIP) budget helps support the ongoing operations and maintenance of the CWF and provides resources for several program integrity systems related to Medicare secondary payer work, audit tracking, and other MIP activities.

SUPPORTING INFORMATION

The Quality Improvement Organization (QIO, formerly the Peer Review Organization or PRO) program budget, which is also funded via a permanent appropriation, supports IT activities such as the QIO Standard Data Processing System (SDPS), Clinical Data Abstraction Centers (CDACs), the Quality Improvement & Evaluation System (QIES), the home health quality assessment system, and operations at the CMS data center.

The Medicaid Management Information System (MMIS) is funded through the State and local administration portion of the annual Medicaid appropriation (see Tab III, Other Accounts). That appropriation includes \$1.8 billion in IT funding administered by the States for MMIS design, development, and operation, as well as non-MMIS automated data processing activities.

Funding is also provided for certain legislative mandates and Administration initiatives.

Key Departmental Initiatives**HHS Enterprise Infrastructure**

CMS's FY 2004 President's Budget includes funding to support Departmental efforts to improve the HHS Information Technology Enterprise Infrastructure. The request includes funds to support an enterprise approach to investing in key information technology infrastructure such as security and network modernization. These investments will enable HHS programs to carry out their missions more securely and at a lower cost. Agency funds will be combined with resources in the Information Technology Security and Innovation Fund to promote collaboration in planning and project management and to achieve common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software.

Unified Financial Management System (UFMS)

The Unified Financial Management System will be implemented to replace five legacy accounting systems currently used across HHS operating divisions. The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. It will also promote the consolidation of accounting operations and thereby reduce substantially the cost of providing accounting services throughout HHS. Similarly, UFMS, by generating timely, reliable, and consistent financial information, will enable agencies and program administrators to make more timely and informed decisions regarding their operations.

SUPPORTING INFORMATION

Key CMS Initiatives**Healthcare Integrated General Ledger Accounting System (HIGLAS)**

A vital component of UFMS is CMS's Healthcare Integrated General Ledger Accounting System. HIGLAS will provide a uniform system to account for the billions of dollars CMS and its contractors spend each year in Medicare benefits and in program management funds. The FY 2004 budget includes funding for HIGLAS in two line items: the Federal Administration activity funds replacement of the Financial Accounting Control System (FACS) while the Medicare Operations activity funds continued implementation of the proposed HIGLAS solution at one Part A and one Part B contractor site. Scheduled activities include a stress test and a final "go" or "no go" decision on phased integration and implementation of the HIGLAS solution. Full implementation for all Medicare contractors, projected for the end of FY 2007, will assist CMS in retaining its unqualified opinion on independent audits of its financial statements, give CMS enhanced oversight of contractor financial operations, provide high quality and timely data for decision-making and performance measurement, and significantly reduce errors in financial reporting.

HIPAA Implementation

In FY 2004, CMS will continue implementation of major provisions of the Health Insurance Portability and Accountability Act (HIPAA). The FY 2004 Medicare Operations request funds several HIPAA-related information technology costs, including:

- ongoing design and development of the information system that will be used to enumerate health plans and health care providers with unique identifiers for use in transactions;
- beginning to assign unique identifiers to providers who are covered entities;
- implementing local systems changes, new standards, and modifications at the fiscal intermediaries, carriers, and DMERCS;
- testing with late providers; and
- improving systems security consistent with HIPAA privacy requirements and the HIPAA security regulation.

Systems Security

CMS is continuing system security efforts to enhance the overall security of CMS systems, prevent and combat cyber-terror, protect sensitive data, and be compliant with the Government Information Security Reform Act (GISRA). The FY 2004 budget provides a minimally acceptable level of funding for ongoing security on

SUPPORTING INFORMATION

internal CMS systems and CMS's external partners' (primarily Medicare contractors) systems. In order to fully comply with GISRA and numerous other legislative and OMB requirements and to better safeguard the sensitive data CMS and its contractors possess, CMS is requesting additional funding for systems security activities as part of a multi-year revitalization plan which is briefly described below.

CMS Revitalization Plan

As part of a multi-year investment fund described in the Executive Summary and Program Management tabs of this Justification, the FY 2004 budget includes \$65 million in 2-year money to begin to address IT challenges in the areas of systems security risk mitigation, modernization of Medicare fee-for-service claims processing, modernization of several databases vital to Medicare and Medicaid program operations, and providing a modern IT infrastructure to effectively support a secure e-gov/e-commerce environment.

Other Information

The HHS Exhibit 53, which will be posted as part of the President's Budget at www.cio.gov, presents the entire CMS IT portfolio distributed by mission area, infrastructure and office automation, architecture and planning, grants management, and grants to States.

SUPPORTING INFORMATION

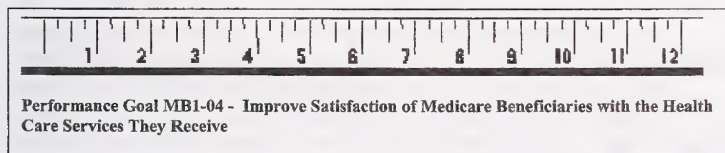
Medicare Benefits

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the Nation's largest health insurance program, which covers approximately 41 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For nearly four decades, this program has helped pay medical bills for millions of older Americans, providing them with comprehensive health benefits they can count on. Few programs, public or private, have such a positive impact on so many Americans.

The integration of CMS's Annual Performance Plan with the budget submission is illustrated below. The CMS has selected representative performance measures to ensure that beneficiaries receive the high-quality care they need and depend on. In addition to the performance goals shown in other sections of this document, several are directly related to Medicare benefits and beneficiary services. For example:

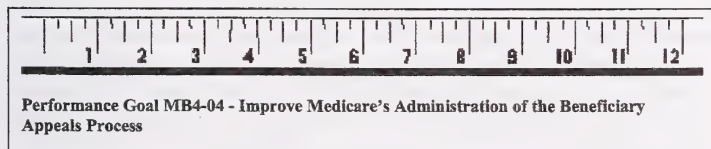
Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-04)

Beneficiaries are CMS's primary customers, and one of CMS's main reasons for being is to assure satisfaction in the experiences beneficiaries have in accessing care for illnesses and injuries when needed, including their access to care of specialists.



Improve Medicare's Administration of the Beneficiary Appeals Process (MB4-04)

The appeals process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denials of payment or service. Under fee-for-service (FFS)



SUPPORTING INFORMATION

Medicare, beneficiaries have the right to appeal a denial of payment by a Medicare fiscal intermediary (FI) or carrier. This appeal comes after the service has been provided. The appeals process takes on added significance under the M+C program because these appeals may also involve pre-service denials of care, thus opening the possibility of restricted access to Medicare services.

The CMS believes that we have selected goals representing our efforts regarding Medicare benefits and beneficiary services that address a range of issues, both administrative and care-related.

SUPPORTING INFORMATION

Clinical Laboratory Improvement Amendments of 1988

Authorizing Legislation - Public Health Service Act, Title XIII, Section 353.

CLIA Summary Table

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
Collections/BA	\$43,731,000	\$43,000,000	\$43,000,000	\$0
FTEs	80	80	78	-2

Overview

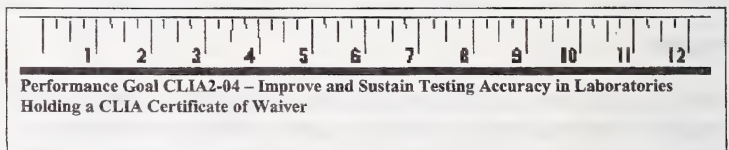
The Clinical Laboratory Improvement Amendments of 1988 (CLIA) establish quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. CLIA applies to all sites which perform laboratory testing either on a permanent or temporary basis, such as physician office laboratories (POLs); hospitals; nursing facilities; independent laboratories; end-stage renal disease facilities; ambulatory surgical centers; rural health clinics; insurance laboratories; Federal, State, city and county laboratories; and community health screenings. CLIA provisions are based on the complexity of performed tests, not the type of laboratory where the testing occurs. Thus, laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other site. In accordance with CLIA regulation, CMS will continue its partnership with the States to certify and to inspect approximately 21,800 laboratories during the FY 2004-2005 survey cycle.

Laboratories exempt from routine Federal inspections include those performing waived tests only, laboratories in which specified practitioners perform only certain microscopic tests, laboratories accredited by approved independent accrediting organizations, and laboratories in States that approve or license clinical laboratories under their own standards. Waived laboratories perform only simple testing and are not generally subject to CLIA requirements, with the exception of following manufacturers' instructions. Laboratories which are accredited, or which operate in exempt States, are inspected by the accrediting organization or the State at the same frequency as CMS-

SUPPORTING INFORMATION

certified laboratories, namely every 2 years. The accrediting organizations and exempt States have standards considered equal to or more stringent than those required under the CLIA statute. Laboratories that are subject to Federal surveys (those performing nonwaived testing) can choose to be surveyed either by CMS or by one of the 6 CMS-approved private accrediting organizations. The CMS survey process is outcome-oriented and utilizes an educational approach to assess compliance.

Currently, 177,300 laboratories are registered with the CLIA program. Approximately 138,565, or 78.2 percent, of these laboratories are classified as waived or provider-performed microscopy laboratories and are not subject to routine onsite inspection. The largest number of laboratories, physician office laboratories (POLs), account for approximately 99,800, or 56 percent, of the laboratories registered under the CLIA program. Approximately 79,200, or 79 percent, of the POLs perform testing classified as waived or as provider-performed microscopy.



Data indicates that CLIA has helped to improve the overall quality of testing in the United States. CMS has found that the total number of quality deficiencies has decreased approximately 40 percent from the first laboratory survey to the second, with further decreases noted on subsequent surveys. The most common deficiencies cited are: not following manufacturer's instructions for test performance, lack of planning to monitor overall lab operations for accuracy and quality, and lack of quality control practice. By identifying and facilitating the correction of deficiencies that affect the accuracy of lab testing, CLIA has advanced the improvement of the quality of testing in laboratories.

Rationale for the CLIA Budget Estimate

The CLIA program is a 100 percent user fee financed program. The budget development methodology is based upon the number of CLIA laboratories, the levels of State agency workloads, and survey costs. CMS determines national State survey workloads by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-

SUPPORTING INFORMATION

exempt laboratories, and accredited laboratories. CMS then sets the national State survey workload at 100 percent of the laboratories to be inspected in a 2-year cycle. Workloads projected for the FY 2004-2005 cycle include surveys of 20,980 non-accredited laboratories, State validation surveys of 810 accredited laboratories, and approximately 1,570 follow-up surveys and complaint investigations.

The CLIA program has evolved past the original projections of the scope and complexity of the program. Effective January 31, 2000, the process of CLIA test categorization was transferred from the Centers for Disease Control and Prevention (CDC) to the Food and Drug Administration (FDA), which enables laboratory device manufacturers to only submit applications to one agency for both device approval and categorization. CMS, the CDC, the FDA, and the States remain focused on the mission to improve the accuracy of tests administered in our Nation's laboratories, thereby improving health care for all. CMS, the CDC, and the FDA have reevaluated the program, procedures, responsibilities, and time lines to continually achieve greater efficiencies, while ensuring that requirements reflect the current standard of practice in laboratory medicine. By being flexible and results-oriented, the CLIA program has remained successful in the dynamic healthcare environment.

SUPPORTING INFORMATION

Audited Financial Statements/Corrective Action Plan
--

In fiscal year (FY) 2002, CMS received an unqualified audit opinion for its financial statements. However, the auditors reported two material weaknesses—financial systems, analyses, and oversight, and Medicare electronic data processing (EDP) controls. The CMS' corrective action plan (CAP) addresses these weaknesses. The CMS updated the CAP for activities through December 31, 2002, and has accomplished the following to correct the weaknesses:

- Tested financial management internal controls during Statement on Auditing Standards (SAS) 70 reviews at 17 Medicare contractors using certified public accounting (CPA) firms.
- Reviewed accounts receivable balances at 15 Medicare contractors using CPA firms.
- Conducted contractor performance evaluation reviews of financial management issues at 6 Medicare contractors.
- Validated financial management CAPs from Medicare contractors.
- Provided additional instruction to our Medicare contractors through formal guidance and training conferences.
- Established regional office/central office workgroups to address four key financial management areas: trend analysis, reconciliations of funds expended to paid claims, corrective action plans, and internal controls.
- Implemented trend analysis to validate the financial data it reports, as well as data reported by Medicare contractors.

Our long-term plan is to develop and implement the CMS Healthcare Integrated General Ledger Accounting System (HiGLAS). This project is a key element of our strategic vision to develop a state-of-the-art accounting system that will encompass all Medicare contractor and CMS financial activities. We will continue to enhance Medicare EDP access controls through improvements in training, risk assessments, system administration, and internal audits.

Mandatory Costs:

- **Claims Review:** In FY 2003, CMS will continue to be responsible for claims review, a part of the substantive testing process for the CFO audit. This activity will be funded through the Medicare Integrity Program (MIP) budget at an

SUPPORTING INFORMATION

estimated cost of \$9.6 million. The methodology for this is outlined in the statement of work for Advance Med and approved for use by the Office of Inspector General (OIG). Generally, it consists of a medical records review of 2,000 claims submitted to Medicare by each Medicare contractor; a national and contractor specific estimate of the Medicare fee-for-service payment error rate is calculated from this review and projected to the program. The OIG oversees this process, which is done by a Medicare Program Safeguards Contractor.

- **SAS 70 Reviews:** CMS's MIP budget will also fund SAS 70 reviews of financial management internal controls at the Medicare contractors. Cost estimates are \$5.5 million in FY 2003 and \$7.5 million in FY 2004.

Discretionary Costs: The Medicare Operations line item within the Program Management account funds the CFO audit, conducted by external financial consultants, and accounts receivable (AR) reviews. In FY 2004, CMS expects to spend \$5.2 million on the audit and \$1.9 million on AR reviews. CMS continues to request discretionary funding for HIGLAS in order to respond to material weaknesses in its financial systems. The FY 2003 President's budget request included \$51 million for this initiative. In FY 2004, we are requesting a total of \$57 million. The CMS is also requesting \$34 million in FY 2004 through its Revitalization Plan to address known security weaknesses in the Medicare contractors' EDP controls.

SUPPORTING INFORMATION

Health Care Fraud and Abuse Control

Health Care Fraud and Abuse Control (HCFAC) Account (dollars in thousands)

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2003/2004 Increase/ Decrease
Medicare Integrity Program	\$699,582	\$720,000	\$720,000	0
FBI	101,000	114,000	114,000	0
OIG & Wedge Funds	<u>209,238</u>	<u>241,000</u>	<u>241,000</u>	0
Total Obligations	\$1,009,820	\$1,075,000	\$1,075,000	0

Authorizing Legislation

Section 1128C of the Social Security Act established the Health Care Fraud and Abuse Control (HCFAC) program. Section 1817 of the Social Security Act established HCFAC in the Federal Hospital Insurance (HI) Trust Fund and specified the levels of funding for the activities in this account. Funds are permanently appropriated and are made available through the apportionment process. Section 1893 of the Social Security Act established the Medicare Integrity Program (MIP). The HCFAC account funds MIP and other health care fraud and abuse control activities. Funds are to be used for prosecutions of health care matters, investigations, audits, inspections, evaluations, as well as for educating consumers and providers.

In addition to MIP, funding is available for HCFAC work carried out by the FBI. Funding levels for MIP and the FBI are spelled out in the statute. Funding also is available for the HHS Office of Inspector General (OIG), the Department of Justice (DOJ) and other HHS agencies. Funding other than that spelled out in statute for OIG is known as "wedge" money, a term from the original negotiations about the bill. The activities and amounts for each agency funded with wedge money are, by statute, negotiated between the Attorney General and the Secretary of HHS.

SUPPORTING INFORMATION

Priorities and Strategies

Reducing fraud, waste, and abuse continues to be a top priority for CMS in FY 2004. We strive in every case to pay the right amount, to a legitimate provider, for covered, reasonable, and necessary services provided in the appropriate setting to an eligible beneficiary.

CMS follows four parallel strategies in carrying out our program oversight activities. They are: prevention, early detection, coordination, and enforcement.

Prevention. CMS identifies problems before a claim is paid, through our payment systems, prepayment medical review activities, and education of providers and beneficiaries.

Early detection. CMS finds problems quickly, using audits and post payment claims reviews, data matches and other sources to detect improper payments.

Coordination. CMS works with others to identify and fight fraud and abuse. CMS recognizes the importance of working with contractors, beneficiaries, law enforcement partners, and other Federal and State agencies to improve the fiscal integrity of the Medicare trust funds.

Enforcement. CMS ensures that action is taken when fraud and abuse is found. CMS will continue to work with our partners, including the DHHS/OIG, Department of Justice (DOJ), State agencies for survey and certification, and State Medicaid agencies to pursue appropriate corrective actions such as restitution, fines, penalties, damages, and program suspensions or exclusions.

SUPPORTING INFORMATION

Medicare Integrity Program Activities

The MIP activity in the HCFAC account provides funds for medical review, benefit integrity, provider and HMO audits, Medicare secondary payer activities, and provider education and training. The following table shows costs, savings and returns on investment (ROI) for each of the MIP activities for the years FY 2002, FY 2003 and FY 2004. For display purposes, the ROI is straight-lined in FY 2004.

(dollars in millions)

	FY 2002			FY 2003			FY 2004		
	Cost	Savings	ROI	Cost	Savings	ROI	Cost	Savings	ROI
Medical Review	\$196	\$3,281	17:1	\$182	\$3,094	17:1	\$182	\$3,094	17:1
Benefit Integrity	103	-	<u>1/</u>	105	-	<u>1/</u>	105	-	<u>1/</u>
Audit	205	2,626	13:1	208	2,704	13:1	208	2,704	13:1
HMO Audits	2	30	15:1	9	135	15:1	9	135	15:1
Medicare Secondary Payer	140	4,170	30:1	146	4,380	30:1	146	4,380	30:1
Provider Education & Training	54	-	<u>2/</u>	70	-	<u>2/</u>	70	-	<u>2/</u>
Total	\$700	\$10,107	15:1	\$720	\$10,313	14:1	\$720	\$10,313	14:1

1/ Because the scope and nature of this work depends largely on activities of other agencies, it is difficult to quantify savings for this activity.

2/ Because of the scope and nature of this work, it is difficult to quantify savings for this activity

Medical Review (MR) MR activities can be conducted either pre-payment or post-payment, and serve to guard against inappropriate benefit payments by ensuring that the medical care provided meets all of the following conditions:

- the service fits one of the benefit categories described in title XVIII of the Act and is covered under the Medicare program;
- it is not excluded by the Act; and

SUPPORTING INFORMATION

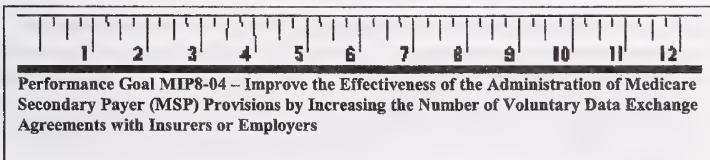
- it is reasonable and necessary within the meaning of section 1862(a)(1)(A) of the Act for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.

Benefit Integrity (BI). BI activities deter and detect Medicare fraud through concerted efforts with the Office of Inspector General (OIG), the General Accounting Office, the Department of Justice, and other CMS partners. In support of BI, CMS conducts proactive data analysis to identify patterns of fraud and make appropriate referrals to law enforcement. CMS follows up on beneficiary complaints that indicate fraud, and support law enforcement as cases are negotiated.

Provider Audit. Auditing is CMS's primary instrument to safeguard payments made to institutional providers who are paid on an interim basis and whose costs are finally settled through the submission of an annual Medicare cost report. The audit process includes the timely receipt and acceptance of provider cost reports, desk review and audit of those cost reports, and the final settlement of the provider cost reports. The audit process includes such administrative functions as intermediary hearings and appeals to the Provider Reimbursement Review Board. The audit effort also helps determine the confidence level in the data reported in the Medicare cost reports and reflects changes in provider behavior.

HMO Audits. CMS contracts with managed care organizations (MCOs) to provide services to Medicare enrollees on a cost reimbursement basis. The agency determines the monthly payments that are made to these MCOs on a prepayment basis and is responsible for the proper settlements of final cost reports. To ensure accurate reimbursement, CMS contracts with an independent CPA firm to audit cost reports submitted for settlement. CMS's performance goal is to increase the ratio of recoveries to audit dollars spent.

Medicare Secondary Payment (MSP) The MSP effort ensures that the appropriate primary payer makes payment for health care services for beneficiaries. The MSP program collects timely and accurate information on the proper order of payers, and makes sure that Medicare only pays for those claims where it has primary responsibility for payment of health care services for Medicare beneficiaries. When mistaken Medicare primary payments are identified, recovery actions are undertaken.



SUPPORTING INFORMATION

Provider Education and Training (PET). PET concentrates on educational activities that communicate appropriate billing practices in compliance with Medicare rules, regulations and manual instructions. It focuses on assisting providers to avoid and detect waste, fraud, and abuse. In addition, some PET activities are funded from the Program Management appropriation. These activities are directed more toward on-going program information so that providers can best serve Medicare beneficiaries and reduce costly claims processing errors.

FY 2004 Funding for MIP

For FY 2004, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides \$720 million for MIP. With these resources, CMS plans to enhance a number of activities in our comprehensive plan. For example:

CMS's medical review activities will emphasize appropriate corrective actions for identified claims payment errors. In addition, CMS will stress a quality improvement program, to ensure that the decisions made by medical review staff are accurate and consistent, and to provide a thorough and efficient medical review process. This approach will enable CMS to reduce the claims payment error rate and assure providers and beneficiaries that we are operating the program in a responsible manner.

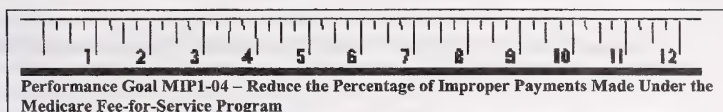
In provider education and training, CMS will emphasize educational activities that communicate appropriate billing practices in compliance with Medicare rules, regulations and manual instructions. Data analysis and interaction with local medical societies, professional associations, and other provider organizations will be used to effectively target CMS's efforts.

Improved provider enrollment activities will ensure that CMS enrolls only legitimate providers. Plans are being developed or are already underway to: provide stricter standards and stronger conditions of participation; conduct onsite visits to verify legitimacy and compliance with standards; increase the frequency of re-enrollment; and collect better ownership and financial solvency information.

Major MIP Initiatives

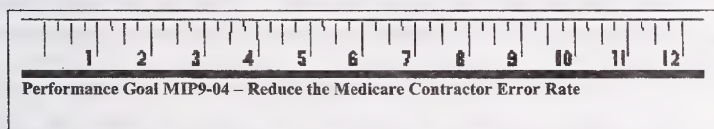
CMS has set a performance goal of reducing the Medicare fee-for-service claims payment error rate to below 5 percent by the end of FY 2004. This goal supports CMS's strategic goal to promote the fiscal integrity of CMS programs. CMS has implemented a Corrective Action Plan designed to minimize the vulnerabilities associated with the complexities of the Medicare payment systems and the large number of contractors, providers and insurers involved in the Medicare fee-for-service program.

SUPPORTING INFORMATION

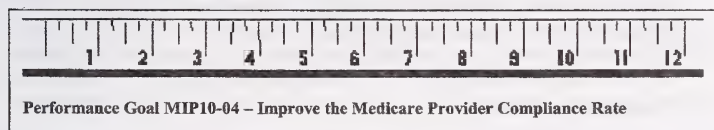


In support of this plan, a comprehensive error rate testing (CERT) program will be fully implemented in FY 2003. CERT is scheduled to provide a single national error rate for the Medicare program by November 2003 and into the future.

CERT will produce error rates for paid claims, with specific rates by contractor, provider type, and type of benefit. These rates can be aggregated to produce national level estimates similar to those in the CFO audit, but with greater accuracy. Under the CERT program, independent medical reviewers will review representative random samples of Medicare claims. The sample claims will be identified as soon as they are accepted into the claims processing system. The independent reviewers will perform a medical review of sample claims that have been paid, and validate denied claims to ensure that the decision was appropriate. The outcomes that CMS anticipates from the CERT program are a paid claims error rate, a claims processing error rate, and a provider compliance rate. The CERT program will provide substantially greater detail and analysis of the vulnerabilities in the current system.



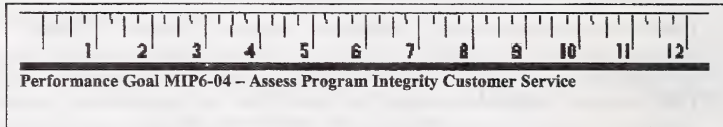
CERT will also be used to establish baseline provider compliance rates. Once a baseline is created CMS will be able to track whether or not corrective actions undertaken by contractors are affecting the provider compliance rate.



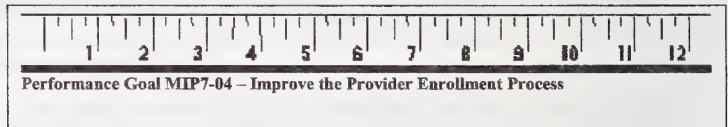
CMS is pursuing a number of other efforts designed to reduce Medicare's improper payment rate. These efforts include:

SUPPORTING INFORMATION

- *Targeting program vulnerabilities.* Since 1999, CMS has used special contractors with program integrity experience to target problem areas. These contractors give CMS the information and flexibility to identify and meet emerging challenges.
- *Improving Customer Service.* CMS has expanded its efforts to assess and improve the customer service provided by the claims-processing contractors, to ensure that they provide accurate, reliable, and relevant information about Medicare coverage and billing to physicians and other health care providers.



- *Clarifying documentation guidelines.* New guidelines are being tested for physicians who provide evaluation and management services to patients. The guidelines are designed to ensure that Medicare pays claims appropriately, while minimizing the paperwork burden for doctors.
- *Strengthening enrollment.* CMS has revised procedures to ensure that the relatively few unqualified providers cannot bill Medicare, while reducing the burden of the Medicare enrollment process on the large number of qualified health care providers.



- *Improving industry compliance.* CMS has supported the Inspector General's development of voluntary compliance guidance for hospitals, medical equipment suppliers, clinical laboratories, home health agencies, third-party billers, Medicare+Choice organizations and other providers.

MIP Contracting Authority

The Medicare Integrity Program includes authority that allows CMS to contract with entities other than our current carriers and fiscal intermediaries to perform specific payment safeguard functions, such as fraud detection and investigation, and provider cost report audits. CMS has used this authority to award contracts to 12 program safeguard contractors (PSCs), and will continue this approach in FY 2003 and FY 2004.

SUPPORTING INFORMATION

CMS has developed a flexible contracting strategy for the PSCs that allows CMS to use different models to address diverse program safeguard needs. To date, CMS has awarded task orders for over 30 different projects. Some of these task orders have been awarded to multiple PSCs. Under these task orders, the PSCs are performing a wide range of activities including the following:

- conducting a data match of California Medicare and Medicaid data;
- developing a centralized data verification project that will assess the accuracy and reliability of national CMS data used in making decisions related to skilled nursing facilities and home health agencies;
- implementing the comprehensive error rate testing program to produce national, contractor specific, benefit category specific and provider specific paid claim error rates; and
- performing benefit integrity work previously done by Medicare fiscal intermediaries and carriers.

The major effort in FY 2003 and early FY 2004 will be the transfer of all benefit integrity functions from the Medicare fiscal intermediaries and carriers to PSCs

Wedge Funding—Medicaid/State Children's Health Insurance Program (SCHIP)

In addition to MIP funding, CMS will use resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding are made by negotiation and agreement between the Secretary of HHS and the Attorney General.

One activity funded from wedge money is the development of Medicaid error-rate baselines. CMS, in conjunction with its consultant contractor, has developed the CMS Payment Accuracy Model (PAM). The CMS PAM has been designed to produce both State-specific and national-level payment accuracy estimates for the Medicaid Program. The model will be pilot tested in 12 States during FY 2003. In FY 2004, the goal is to pilot test the model in up to 25 States, increasing the number of participating States from previous years in order to ensure that the pilot study is representative. Additional efforts to encourage participation from larger States and from States with substantial managed care programs will be essential. CMS intends to prepare final specifications for the CMS PAM Model based upon reports and findings from these States in anticipation of future national implementation.

In addition, the FY 2004 budget reflects plans to provide \$20 million from wedge funds to support the Medicaid financial management project. This would provide resources for additional financial management activities, including additional staff to improve the fiscal integrity of the Medicaid program and to strengthen Federal oversight of the States' financial practices. Other Medicaid and SCHIP projects are under consideration.

SUPPORTING INFORMATION

Program Assessment Rating Tool**Medicare Integrity Program**

A PART assessment was conducted for this program and helped inform the FY 2004 budget policy. A summary of the PART assessment follows.

Final PART Score

Medicare Integrity Program (MIP) 85 percent

The Medicare Integrity Program provides mandatory funds to promote the integrity of the Medicare trust funds through fraud and abuse control activities.

The PART assessment found that the program has a clear purpose, is managed well overall and relies on performance measures that are directly relevant to the program purpose. This is reflected in the reduction of the Medicare error rate, which has declined from 14 percent of fee-for-service payments in 1996 to 6.3 percent in 2001.

The assessment noted that CMS is developing sub-national performance measures to produce contractor, provider and benefit-specific error rates, and developing provider compliance rates to identify providers who need assistance with accurate billing.

The assessment also noted that although CMS has an effective national performance measure, it does not require fiscal intermediaries and contractors to commit to specific error rates. Also, CMS contracts with fiscal intermediaries and carriers on a cost basis, and budgets most MIP funds based on activity level. As a result, the number of payment errors does not affect contractor reimbursements.

Activities or Corrective Actions to Redress Any Deficiencies

As a result of the PART process, CMS intends to further reduce the Medicare fee-for-service error rate to 4 percent by FY 2008. In addition, CMS has included the following two new program integrity goals in the FY 2004 Annual Performance Plan:

- Reduce the Medicare Contractor Error Rate (MIP9-04): By FY 2008, every Medicare contractor will have an error rate of 5 percent or less.
- Improve the Medicare Provider Compliance Rate (MIP10-04): By FY 2008, CMS will significantly improve the Medicare provider compliance rate.

Note that although the Block /Formula Grant PART tool was found best suited to assess the MIP program, MIP does not fund block grants or formula grants.

Program: Medicare Integrity Program (HCFA)

Agency: Department of Health and Human Services
Bureau: Centers for Medicare and Medicaid Services

Rating: Effective
Program Type: Block/Formula Grants

Program Summary:

This program funds a variety of efforts to fight fraud and abuse in the Medicare program.



- ☒ Results Achieved
☐ Results Not Demonstrated
☒ Measures Adequate
☐ New Measures Needed

Key Performance Measures

Key Performance Measures	Year		Target	Actual
	1996	2000		
Long-term Measure: Medicare national fee-for-service error rate	1996		14%	
	2000	7%	6.8%	
	2001	6%	6.3%	
	2008	4%		
Long-term Measure: Percentage of contractor-specific error rates below national Medicare error rate	2005	25%		
	2006	50%		
	2007	75%		
	2008	100%		
Long-term Measure: Provider compliance error rates versus previous year (baseline under development)	2005	+20%		
	2006	+20%		
	2007	+20%		
	2008	+20%		

The assessment found the program purpose is clear and is reflected in the reduction of the Medicare Error Rate, which measures the level of erroneous fee-for-service claims. The Medicare error rate, the key measure of the program's overall effectiveness, has declined from 14 percent of fee-for-service payments in 1996 to 6.3 percent in 2001. Additional findings include:

1. The program is well managed and relies on performance measures, such as the Medicare error rate, that are directly relevant to its purpose.
2. The Administration is developing sub-national performance measures that will identify more specific error rates. In addition, the Administration is developing provider compliance rates to identify providers that may require additional assistance billing accurately for Medicare services.
3. Although the program has an effective national performance measure, it does not require its partners to commit to national or subnational error rates.
4. CMS hires contractors on a cost basis, and budgets most MIP funds based on activity level (e.g. number of claims reviewed). As a result, a contractor's reimbursement is unaffected by the number of claims payment errors made.

In response to these findings, the Administration will:

1. Complete development of contractor specific error rates and require contractors to commit to reducing their error rates.
2. Pursue the "Performance-based Outcomes Pilot" that will explore linking award fees to performance.

Program Funding Level (in millions of dollars)

2002 Actual	2003 Estimate	2004 Estimate
700	720	720

SUPPORTING INFORMATION

State Grants and Demonstrations
--

Authorizing Legislation - The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170), Title II and the Trade Act of 2002 (P.L. 107-210), Title II.

State Grants and Demonstrations Summary Table

	FY 2002 Actual	FY 2003 President's Budget 1/	FY 2004 Estimate	Increase/ Decrease
<i>Ticket to Work</i>				
Section 203 – Medicaid Infrastructure Grants	\$25,000,000	\$ 30,000,000	\$35,000,000	+\$5,000,000
Section 204 - Demonstration to Maintain Independence & Employment	\$42,000,000	\$42,000,000	\$42,000,000	\$0
<i>Subtotal – Ticket to Work Appropriation/BA</i>	\$67,000,000	\$72,000,000	\$77,000,000	+\$5,000,000
<i>Trade Act – Qualified High-Risk Pools</i>				
Subsection (a) Seed Grants		\$20,000,000	\$0	-\$20,000,000
Subsection (b) Operations		\$40,000,000	\$40,000,000	\$0
<i>Subtotal – High-Risk Pools Appropriation/BA</i>		\$60,000,000	\$40,000,000	-\$20,000,000
<i>Total Appropriation/BA</i>	\$67,000,000	\$132,000,000	\$117,000,000	-\$15,000,000
Unobligated Balance, Start of Year	\$40,199,000	\$81,706,000	\$141,604,000	+\$59,897,000
Prior Year Recovery	\$0	\$1,125,000	\$0	-\$1,125,000
Unobligated Balance, EOY	\$81,706,000	\$141,604,000	\$163,876,000	+\$22,272,000
Obligations	\$25,493,000	\$73,227,000	\$94,728,000	+\$21,500,000

1/ This column reflects the current estimate for FY 2003. Budget authority (BA) for the Ticket to Work grant programs remains as \$72 million for FY 2003. Budget authority for the High-Risk Pools was non-existent at the time of the FY 2003 President's Budget. Legislation which established the high-risk pool grant programs was passed on August 6, 2002, after the FY 2003 President's Budget was formulated.

TICKET TO WORK GRANT PROGRAMS**Background**

Title II of the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) established two grant programs starting in FY 2001. Section 203 of the Act provides an appropriation each year from FY 2001 to FY 2011 for infrastructure grants to support the design, establishment, and operation of State infrastructures that provide items and services to support working individuals with disabilities. Section 204 provides for an appropriation of \$42 million for each of the fiscal years from 2001 to 2004 and \$41 million for both FY 2005 and FY 2006 for demonstration projects. The demonstration projects will evaluate the potential benefits of providing Medicaid services to workers with physical or mental impairments that, without medical intervention, have the potential to result in disability.

Funding

In FY 2004, the budget authority provided by statute for the two grant programs totals \$77 million. Section 203 of this Act authorizes and appropriates \$35 million for 100 percent Federally-funded Medicaid infrastructure grants to States. Section 204 of this Act authorizes and appropriates \$42 million for demonstrations to maintain independence and employment.

Grants Awarded and Demonstrations Approved

As of December 31, 2002, a total of 41 entities (40 States and the District of Columbia) have been approved for funding from the Infrastructure Grant Program since its inception. For FY 2003, a total of 36 entities (35 States and the District of Columbia) will receive funding through the Medicaid Infrastructure Grant Program. With this funding, the recipients plan to make systemic changes that will help individuals with disabilities gain employment and retain their health care coverage. These changes are designed to increase Medicaid buy-in programs and enhance State personal assistance service programs.

Additionally, three States (Rhode Island, Texas, and Mississippi) and the District of Columbia have been awarded Demonstration to Maintain Independence and Employment grant funding since the program's inception. States implementing demonstration grant programs will provide Medicaid-equivalent services to targeted populations of working individuals with disabilities. The demonstration projects will be used to evaluate the impact of providing Medicaid benefits to a working person with a potentially severe disability. The State demonstration projects approved so far will cover the HIV/AIDS, multiple sclerosis, and bipolar/schizophrenia populations.

SUPPORTING INFORMATION

QUALIFIED HIGH-RISK POOLS**Background**

Part of Title II of the Trade Act of 2002 (P.L. 107-210) amends the Public Health Service Act by adding Section 2745, which addresses promotion of qualified high-risk pools for assisting "high-risk" individuals who may find private health insurance unavailable, unaffordable, or undesirable. This section establishes: (1) seed grants to States for the creation and initial operation of a qualified high-risk pool for those States that do not have one as of the date of legislative enactment and (2) grants to States for operation of qualified high-risk pools.

Funding

The legislation provides an appropriation of \$20 million in FY 2003 for funding a State's costs for creation and initial operation of a qualified high-risk pool. In addition, an appropriation of \$40 million is provided in both FY 2003 and FY 2004 for the operation of qualified high-risk pools. The FY 2003 funding is available for obligation until the end of FY 2004, and the FY 2004 funding is available for obligation until the end of FY 2005.

Status

CMS sent letters to all governors and State insurance commissioners on November 26, 2002, announcing the availability of seed grant funding for the establishment and initial operation of qualified high-risk pools. The letter included grant application information. The deadline for States to apply to CMS is March 31, 2004.

CMS will send letters to all governors and State insurance commissioners in early 2003 announcing the availability of grant funding for the operation of existing qualified high-risk pools. The letter will include grant application information. The deadlines for States to apply for the matching operation grant will be published in the grant application information.

SUPPORTING INFORMATION

National Medicare & You Education Program

Beneficiary education continues to be a high priority for CMS. People with Medicare are being asked to make complex choices about their health care and health care financing. As a result, beneficiaries and their caregivers need to be able to access the information they need to understand their health plan choices and to make informed health decisions. Consumer research indicates that beneficiaries are often confused or do not know where to go to meet their information needs. The CMS's national education program, *Medicare & You*, educates Medicare beneficiaries so they can make informed health decisions based on accurate, reliable, relevant, and understandable information.

Medicare & You is a dynamic education program that ensures that CMS effectively and efficiently reaches beneficiaries. The CMS systematically studies the information needs of Medicare beneficiaries, their advocates, and CMS's partners to continually make enhancements and improvements to increase program effectiveness. Evaluation and assessment of the communication channels are also conducted annually to determine methods for improving the services and information provided in the upcoming year. A significant improvement in the public's ability to make more informed health care choices about issues as complex as health and health care financing can only be realized over time.



Performance Goal MO9-04 - Improve Beneficiary Understanding of Basic Features of the Medicare Program

Providing the approximately 41 million Medicare beneficiaries with the knowledge and skills needed to make fully-informed choices about their health plan options is challenging, especially since this population is very diverse in terms of education and literacy.

Therefore, the *Medicare & You* education program employs a variety of communication channels and information activities to reach and inform the intended audiences including: printed materials, 1-800-MEDICARE toll-free telephone services, Internet sites, community-based education targeted to vulnerable populations with access issues, enhanced counseling at the local level from State Health Insurance and Assistance Programs (SHIPs), partnering with organizations that have vehicles and tools for better reaching specific audiences, and a national ad campaign to ensure that people know where to access information when they need to make decisions.

SUPPORTING INFORMATION

Medicare & You began in October 1997 with the passage of the Balanced Budget Act (BBA). The first 3 years of the program were funded primarily by user fees because of the emphasis on Medicare+Choice requirements. However, the scope of the *Medicare & You* program extends beyond BBA requirements to satisfy multiple mandates or projects that have been in existence for several years. Therefore, in addition to the Medicare+Choice user fee, the *Medicare & You* campaign is funded with Quality Improvement Organization and Program Management funds. Since FY 2001, Program Management funds have been the major funding source due to reductions in the user fee mandated by the Balanced Budget Refinement Act (BBRA) of 1999.

Starting in FY 2001, Section 522 of the BBRA amended the user fee, limiting the maximum amount that can be obtained from Medicare+Choice organizations, to a percentage of \$100 million based on the annual average enrollment in Medicare+Choice organizations. Application of this formula equates to user fee collections of \$14 million in FY 2004. This user fee number is subject to change as Medicare+Choice enrollment rises or falls.

FY 2002 Major Program Activities

- The 2002 *Medicare & You* handbook was mailed to approximately 34 million Medicare beneficiaries in beneficiary-preferred language (English or Spanish) and media (Braille, audiocassette, large print) in October 2001. Each month, approximately 200,000 new beneficiaries receive the handbook as they enroll in Medicare. Additionally, approximately 1.4 million copies were provided to health plans, Congressional staff, partners, and agents.

The 2003 *Medicare & You* handbook (which was distributed in October 2002) was developed during this fiscal year. Improvements to this handbook were made based on consumer suggestions and testing, and new information was incorporated to inform beneficiaries of program changes.

- On October 1, 2001, the 1-800-MEDICARE toll-free telephone line was expanded to provide access to customer service representatives 24 hours a day, 7 days per week. The CMS wants to ensure a high level of customer service by providing beneficiaries and those acting on their behalf answers to their questions at any time. Call volumes significantly increased in FY 2002, and CMS expects that the volume of calls during expanded hours will grow as publicity around these services continues and as more beneficiaries learn that they can get information they need anytime during the day or night.
- In FY 2002, a new beneficiary decision tool, the Medicare Personal Plan Finder (MPPF), was introduced to www.medicare.gov. The MPPF was specifically designed to assist beneficiaries in understanding their health plan options and selecting the plan that best meets their needs. Additionally, nursing home quality information was added to the content of the web site.

SUPPORTING INFORMATION

- A comprehensive national ad campaign was introduced in the fall of 2001. Research indicates that adults aged 60 and over are among the heaviest viewers of television and they tend to be very responsive to media. Most people with Medicare also seek information when a specific need or problem arises. The CMS purchased a mix of ad buys (TV, radio, print, Internet) carefully designed to reach the maximum number of people through the most effective outlets in the most cost-effective way.
- The CMS continued their grant relationship with the SHIPs, which are largely volunteer-based organizations located in all 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands. They provide information and direct beneficiary counseling on more complex Medicare related topics, including Medicare entitlement and enrollment, health plan options, Medigap and long-term care insurance, and Medicaid. The services provided reflect unique social, cultural, and geographical needs of the population. In FY 2002, nearly 2.5 million beneficiaries were served through telephone and face-to-face assistance and outreach activities from 12,000 highly trained volunteers at the State level. At the local level, approximately 30,000 outreach and education activities were conducted.

The CMS continued their alliances with 140 network partners (e.g., associations, advocacy groups, corporations, State and local government offices, employers, and unions) working cooperatively in public-private partnership to meet the education program goals at the State and local levels.

- The CMS continued activities that directly support the education program and the communication channels, including formative research, evaluation, and assessment of the channels and consumer experiences with the health plans and services through the Consumer Assessment of Health Plan Study (CAHPS).

FY 2003 and FY 2004 Major Program Activities

The CMS plans to continue the services and customer support described in the FY 2002 base. A key component of this dynamic program is to ensure that improvements and enhancements are made based on formative research, evaluation, and assessment activities conducted each year. Much emphasis is focused on improving education products and services each year based on evaluation and assessment results.

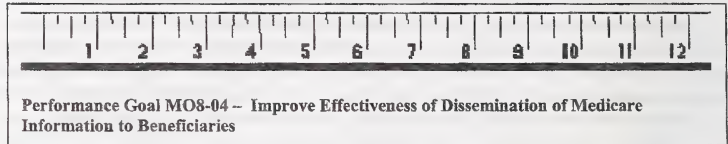
For example, the second national ad campaign (which started in June 2002 and continues through FY 2003) has been refined and improved based on lessons learned from the first campaign that was primarily conducted in the fall of 2001. Findings confirm that many of the first campaign activities were approached correctly. However, refinements in strategies and methods are specifically being addressed in the following areas for future campaigns.

- Based on research indicating that people with Medicare want information when they need it, the second campaign focused on distributing ads more continuously

SUPPORTING INFORMATION

throughout the year rather than frequently broadcasting ads during a short period of time. Also, instead of focusing on a well-known personality, the ads were more targeted with a specific focus on the 1-800-MEDICARE and www.medicare.gov information sources. The CMS anticipates that this new approach will ensure awareness and retention of knowledge about 1-800-MEDICARE and www.medicare.gov throughout the year.

- The CMS continues to focus on secondary target populations; e.g., Hispanic beneficiaries and their caregivers, but will also expand efforts to all caregivers and people enrolling in Medicare for the first time.



The FY 2004 request level is a straight-line from the FY 2003 request level.

SUPPORTING INFORMATION

National Medicare & You Education Program Budget—FY 2004

Budget Line Items	FY 2004 Planned Obligations	
Beneficiary Materials	\$28.0M (\$14.0M UF) (\$14.0M PM)	National handbook with comparative information in English and Spanish (national & monthly mailing); <i>targeted materials only to the extent that funding is available after payment of the handbook</i>
1-800 MEDICARE (toll free line)	\$67.0M (\$67.0M PM)	Full call center and print fulfillment services with 24 hours a day, 7 days a week access to customer service representatives for 12 months
Internet	\$5.0M (\$4.0M PM) (\$1.0M QIO)	Maintenance, updates and enhancements to existing interactive databases and web sites; funding levels allow for additional server support, content management, and new interactive databases to support the CMS quality initiative
Community-Based Outreach	\$12.5M (\$12.5M PM)	SHIP grants; local level support, access initiatives (HORIZONS)
Program Support Services	\$37.0M (\$24.5M PM) (\$12.5M QIO)	Ad Campaign at \$20.5M; \$12.5M for CAHPS; \$4.0M for evaluation & assessment, formative research, and consumer testing
TOTALS	\$149.5M \$122.0M Program Management \$14.0M User Fee \$13.5M Quality Improvement Organizations	

SUPPORTING INFORMATION

State Children's Health Insurance Program
--

Authorizing Legislation - The Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).

Summary Table

	2002 Actual	2003 President's Budget	FY 2004 Estimate	Increase or Decrease
Budget Authority	\$3,090,000,000	\$3,150,000,000	\$3,150,000,000	\$0
BBRA—Additional Funding for Territories	\$ 25,200,000	\$ 25,200,000	\$ 25,200,000	\$0
Total Budget Authority	\$3,115,200,000	\$3,175,200,000	\$3,175,200,000	\$0
BIPA - Redistribution from Fiscal Year Allotment:				
FY 1999	\$2,818,627,000			N/A
FY 2000		\$2,206,440,000		N/A
FY 2001			TBD	N/A
Total Budgetary Resources	\$5,933,827,000	\$5,381,640,000	\$3,175,200,000	\$2,206,440,000

BACKGROUND

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP) under title XXI of the Social Security Act. This program is the largest single expansion of health insurance coverage for children in more than 30 years and improves the access to health care and the quality of life for millions of vulnerable children under 19 years of age. Under title XXI, States were given the option to expand Medicaid (title XIX) coverage, set up a separate child health program, or have a combination of both a Medicaid expansion and a separate child health program.

As of September 1999, all States, territories, and the District of Columbia had approved SCHIP plans. CMS continues to review the States' SCHIP plan amendments as the States respond to the challenges of operating this program. As of December 2002, 139 amendments to SCHIP plans and 14 SCHIP-related waivers were approved to enroll even more low-income uninsured children and adults. Of these 14 waivers,

SUPPORTING INFORMATION

8 were approved under the regular SCHIP section 1115 demonstration process (MD, MN, NJ, NM (2), OH, RI and WI) and 6 (AZ, CA, CO, IL, NM and OR) under the Health Insurance Flexibility and Accountability demonstration initiative (HIFA). The States continue to be committed to the goals of the SCHIP program, including quality, access and retention.

As discussed in the Medicaid section, in August 2001, the Administration announced the HIFA demonstration initiative. The HIFA initiative encourages States to develop comprehensive health insurance coverage approaches that utilize available Medicaid and SCHIP funding to address insurance coverage for individuals with incomes less than twice the Federal poverty level. HIFA gives States the programmatic flexibility to increase health insurance coverage through support of private group health coverage.

RECENT LEGISLATIVE CHANGES

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) extended the period of availability for FY 1998 and FY 1999 State allotments to FY 2002. The BBA originally provided the States 3 years to expend their fiscal year allotments. However, some States did not have their SCHIP programs operational until 1999, the second year after the authorizing legislation was enacted.

As the BBA originally intended, BIPA allowed States that fully expended their FY 1998 and FY 1999 allotments to receive a portion of the redistribution pool. However, the period of availability for both fiscal year allotments ended after September 30, 2002, and \$1,259,426,000 in SCHIP funding is no longer available to the States and other jurisdictions.

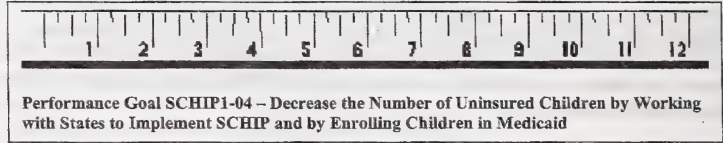
ENROLLMENT

The following table reflects the estimated annual enrollment in number of person-years receiving enhanced Federal matching under title XXI and does not include children covered with regular Medicaid (title XIX), parents, pregnant women or childless adults receiving SCHIP benefits through section 1115 waivers.

SCHIP Enrollment (Person-Years in Millions)

	FY 2002	FY 2003	FY 2004
Children Enrolled	4.2	4.8	4.8

SUPPORTING INFORMATION

**FUNDING**

For FY 2004, the statute authorizes and appropriates \$3,150,000,000 for SCHIP allotments to States, territories, and the District of Columbia. Also, in FY 2004, the Balanced Budget Refinement Act of 1999 (BBRA) authorizes and appropriates an additional \$25,200,000 for SCHIP allotments to commonwealths and territories. The total funds available for CMS to grant to States, commonwealths, and territories for the State Children's Health Insurance Program in FY 2004 will be \$3,175,200,000. These funds will be made available to purchase meaningful health care coverage for millions of low-income, uninsured, primarily children under 19 years of age and at or below 200 percent of the Federal poverty level.

IMPACT OF PROPOSED LEGISLATION

A number of legislative proposals are being presented. The proposals include a major reform of Medicaid and the State Children's Health Insurance Program (SCHIP), as well as other legislative proposals. The other legislative proposals are described below.

Extend SCHIP Funds

This legislative proposal would extend the availability of the 2000 allotments that will expire at the end of 2003 for one additional year until the end of FY 2004. The Balanced Budget Act of 1997 (BBA) authorized and funded the State Children's Health Insurance Program giving States three years to spend their allotments. Under current law, any unspent funds at the end of three years are reallocated to States that have already used all of their funds. After one year, any unspent redistributed funds revert to the Treasury. After FY 2002, \$1.2 billion in SCHIP funding expired and will return to the Treasury. According to current estimates, \$831 million in SCHIP funds will expire at the end of FY 2003. This proposal would extend the availability of FY 2000 funds until FY 2004 enabling States to maintain coverage levels as well as provide additional health coverage to more uninsured Americans under HIFA.

Five year budget impact: \$470 million

Ten year budget impact: \$565 million

SUPPORTING INFORMATION

Tax Credits for Health Insurance

Please refer to the Medicaid proposed law section for the description of this proposal.

Special Enrollment Period in the Group Market for Medicaid/SCHIP Eligibles

This proposal would make it easier for Medicaid and SCHIP beneficiaries to enroll in private health insurance, by making eligibility for Medicaid and SCHIP a trigger for private health insurance enrollment outside the plan's open season. This proposal will help States implement premium assistance programs in Medicaid and SCHIP.

Budget Impact: Negligible.

PROGRAM ASSESSMENT RATING TOOL

A PART assessment was conducted for this program and helped inform the FY 2004 budget policy. A summary of the PART assessment follows.

Final PART Score

State Children's Health Insurance Program (SCHIP)	71 percent
---	------------

Summary of OMB Analysis of Program Strengths and Weaknesses

The State Children's Health Insurance Program (SCHIP) provides funds to States to initiate and expand health insurance coverage to uninsured low-income children less than 19 years of age.

The assessment found the program purpose is clear. Additional findings include:

1. Existing performance measures, such as the number of children enrolled in the program do not measure what impact the program is having on the health of those children. The measures do not capture health outcomes or the efficiency of the program. Without a core set of performance measures, the CMS has not been able to adjust program priorities based on national goals or to improve the program's performance in the areas of utilization, access, health outcomes, or financial management. At this time, CMS does not perform risk assessments or calculate error rates.
2. In addition, GPRA goals for SCHIP do not currently reflect appropriate national outcome goals, such as those suggested by HHS Healthy People 2010, including tracking leading health indicators such as immunization and access to health care.

SUPPORTING INFORMATION

3. Lastly, while GPRA goals for SCHIP measure increases in enrollment, they are not currently able to measure the impact of SCHIP on the rate of uninsured children.

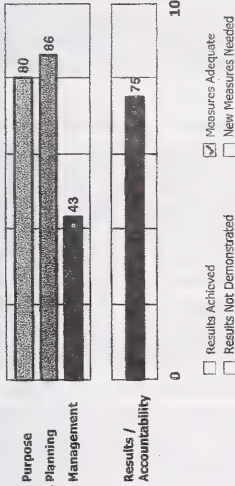
Activities or Corrective Actions to Redress Any Deficiencies

In response to these findings, CMS will continue to develop with States a core set of national performance measures to evaluate the quality of care received by low-income children. In addition, we intend to further investigate the development of a methodology to measure SCHIP improper payments and the development of additional GPRA goals.



Program: State Childrens Health Insurance Program

Agency: Department of Health and Human Services
Bureau: Centers for Medicare and Medicaid Services



Key Performance Measures

	Year	Target	Actual
Long-term Measure: Increase in the number of additional children enrolled in regular Medicaid or SCHIP as compared to previous year	2000	1million	>1million
	2001	1million	>1million
	2002	1million	>1million
Long-term Measure: Implement national health care performance measures across Medicaid and SCHIP (Measures under development)			
Annual Measure: (Measures under development)			

Rating: Moderately Effective

Program Type: Block/Formula Grants

Program Summary:

The State Children's Health Insurance Program (SCHIP) provides funds to states to initiate and expand health insurance coverage to uninsured low-income children less than 19 years of age.

The assessment found the program purpose is clear, program planning is very effective, and program results are evident. Since the inception of SCHIP coverage more children have been enrolled in Medicaid and SCHIP, and the overall number of uninsured children has decreased. SCHIP was designed to give states more flexibility to design their health care programs and 34 states have used this additional flexibility. In addition, States annually report on performance measures and enrollment. Additional findings include:

1. Existing performance measures, such as number of children enrolled in the program do not measure what impact the program is having on those children. The measures do not capture health outcomes or the efficiency of the program. Without a core set of national performance measures, the Centers for Medicare and Medicaid Services (CMS) has not been able to adjust program priorities based on national goals or to improve the program's performance in the areas of utilization, access, health outcomes, or financial management. At this time, CMS does not perform risk assessments or calculate error rates.
2. GPRA goals for SCHIP do not reflect appropriate national outcome goals, such as those suggested by HHS in "Healthy People 2010," including tracking leading health indicators such as immunization and access to health care.
3. While GPRA goals for SCHIP measure increases in enrollment, they do not measure the impact of SCHIP on the rate of uninsured children.

In response to these findings, CMS should:

1. Develop a core set of national performance measures with States to evaluate the quality of care received by low-income children.
2. Develop new annual and long term GPRA goals (e.g. measuring the impact of SCHIP on the rate of uninsured children), and
3. Develop a methodology to measure SCHIP improper payments, including producing error rates.

(For more information on this program, please see the Department of Health and Human Services chapter in the Budget volume.)

*Program Funding Level (budget authority in millions of dollars)

2002 Actual	2003 Current Law	2004 Current Law
3,115	3,175	3,175

*As authorized and appropriated in P.L. 105-33.

SUPPORTING INFORMATION

SIGNIFICANT ITEMS IN
THE SENATE COMMITTEE REPORT FOR FY 2003

FY 2003 Senate Committee Report Language (107-216)

The following section represents FY 2003 Congressional requirements for reports and significant items derived from Senate Report 107-216. These actions discussed below are contingent on inclusion of similar language and funding in the final FY 2003 appropriation and related reports. Additional items may be transmitted at a later date as a result of the final Conference report.

Item

Medicare Contractors-- The Committee believes that it is critical for Medicare contractors to be adequately funded. It is for this reason that the Committee has continued to increase Medicare contractor funding over the years. However, the Committee is concerned that the funding appropriated for Medicare contractor activities is not being appropriately distributed by CMS to its Medicare contractors. The Committee expects CMS to manage these resources so that Medicare contractors have the funding needed to handle total workloads, which are steadily increasing. The Committee also expects funding to be provided to Medicare contractors in a timely manner. Further, the Committee strongly recommends CMS eliminate the 5 percent cap on transferring funds among functions so that contractors have greater flexibility to manage their resources in a manner that best matches programmatic needs. The Committee expects CMS to include, within its fiscal year 2004 congressional justification, a report on how fiscal year 2003 resources were allocated to Medicare contractors. (Page 175)

Action Taken or to be Taken

The CMS agrees that it is critical for Medicare contractors to receive adequate funding for the essential functions they perform. The CMS makes every effort to ensure that the President's budget request adequately supports contractor operations and to manage the resources it receives so the contractors can perform their jobs. For example, in FY 2002, there was an unanticipated increase in bills/claims workloads due to several factors, including a large number of beneficiaries migrating from Medicare managed care to the fee-for-service alternative. As this occurred after the submission of the President's budget request, funding was very tight throughout the year, but CMS worked with the contractors to ensure they had the necessary funds to accomplish all critical work.

The CMS distributes funds to the contractors in as timely a manner as possible given the constraints imposed by continuing resolutions. The CMS is currently awaiting passage of the annual appropriation before providing full-year funding to the contractors.

The CMS uses the 5-percent cap on transferring funds among functions as a tool to ensure that funds designated for a specific purpose are actually used for that purpose.

SUPPORTING INFORMATION

Contractors can, however, request CMS approval to adjust funds among budget lines. The CMS has waived this requirement as part of a pilot with three contractors. By testing this concept with a few contractors, we can better determine whether a broader waiver of this requirement (to all fiscal intermediaries and carriers) would be beneficial.

Once CMS receives its FY 2003 appropriation, it will finalize its FY 2003 operating plan and provide additional information to the Committee.

Item

Native Hawaiians in Waimanalo, Hawaii--The Committee has been very pleased with the efforts of CMS under its demonstration authority to address the extraordinary adverse health status of Native Hawaiians in Waimanalo, Hawaii. The Committee urges an additional focus upon American Samoan residents in that geographical area utilizing the expertise of the Waimanalo Health Center and its Maui Ola program. (Page 175/176)

Action Taken or to be Taken

CMS awarded a 5-year, \$2.5 million project to the Waimanalo Health Center in FY 2000 to support a demonstration project exploring the use of preventive and indigenous health care expertise to improve the health status of Native Hawaiians. We do not have available funds for a new grant directed toward American Samoan residents, but there are substantial unexpended funds under the current grant. These funds might be sufficient to support an expansion of the current project, to include activities directed at the American Samoan population.

Item

Contemporary Models for Pharmacists' Services--The Committee strongly urges the Secretary of Health and Human Services to implement the MedPAC's recommendation to assess contemporary models for pharmacists' services to ensure that seniors have access to this important patient care. The Committee urges the Secretary to consult with various national organizations representing pharmacists and pharmacies and to report back to Congress within this fiscal year. (Page 176)

Action Taken or to be Taken

DHHS has conducted several initiatives over the past few years related to pharmacists' services. In FY 2002, the Health Resources and Services Administration (HRSA) contracted with the American Pharmaceutical Association (APhA) to help safety net health care providers deliver high-quality pharmacy services for uninsured and underserved Americans. Community health centers, AIDS drug assistance programs, and other community health projects supported by HRSA will be able to obtain pharmacy advice and technical assistance from the new Pharmacy Services Support Center in Washington, D.C.

In FY 2000 and FY 2001, HRSA awarded grants to expand clinical pharmacy services at seven health center networks. The supplemental grants went to health center sites in

SUPPORTING INFORMATION

Arizona, Iowa, Massachusetts, Michigan, Mississippi, Utah, and Washington. In addition to dispensing drugs, services provided in the demonstration grants include patient education and consultation, checking for potential drug interactions, methods to make sure patients adhere to prescribed drug therapy, and regular monitoring of health outcomes.

Some States are operating disease management programs that offer pharmaceutical care management to low-income populations.

CMS is considering demonstration models of pharmacy management for certain chronic diseases such as hypertension, as part of its ongoing efforts to test new service delivery models for Medicare beneficiaries.

Item

Consideration of New Technologies, Procedures and Products for Medicare Coverage-- The Committee remains extremely concerned over CMS' continuing failure to articulate clear guidelines and to set expeditious timetables for consideration of new technologies, procedures and products for Medicare coverage. A particularly troubling example is CMS' lengthy delays and failure to articulate clear standards regarding Medicare coverage of positron emission tomography (PET). The effect of these delays in instituting Medicare coverage is to continue to deny the benefits of these technologies and procedures to Medicare patients. The Committee also remains concerned that CMS appears to be requiring some new technologies to repeat clinical trials and testing that have already gained FDA approval. The Committee is also concerned that CMS appears to be requiring substantially different levels of evidence to approve various new products for Medicare coverage. For example, very little documentation is required for approval of magnetic resonance angiography (MRA), while voluminous amounts of data are required to make a coverage decision on PET. The Committee remains concerned that the 120-person Medicare Coverage Advisory Committee may be further delaying coverage decisions and creating unnecessary costs for the Medicare program. These include the commissioning of studies that are not based on sound, established scientific principles. Because of the possible duplication of efforts among HHS agencies and related unnecessary costs to the Medicare program and the Department, the Committee again asks that the Secretary take a leadership role in resolving this matter expeditiously. (Page 176)

Action Taken or to be Taken

CMS has established, via a Federal Register notice in April 1999, a process by which any party can request a national coverage decision. All parties can remain informed as to the process used to reach that decision and a timetable under which we commit to a response to the request within 90 days. CMS has revamped the Medicare coverage process, recognizing that an open, public, and participatory process will result in public understanding and buy-in with our evidence-based approach to coverage. As we gain experience with the open process, our decision-making has become more predictable and timely. In fact, since the process was established, we have made more coverage decisions than in the previous several years combined. CMS continues to

SUPPORTING INFORMATION

pursue revisions to the coverage process, including changes to efficiently implement section 522 of the Benefits Improvement and Protection Act of 2000.

It is possible that due to the complexity of an issue or the controversy surrounding it in the clinical community, that our answer in the 90 days may not always be a yes or no. We may need to request a technology assessment from an evidence-based practice center or we may need to refer an issue to our expert group, the Medicare Coverage Advisory Committee (MCAC). If so, more time will be needed. If that is the case, we will post this information, along with other information on the status of the request, on our web site, in order that the requestor and other interested parties can stay informed. It is our expectation that only a small percentage of issues we review will be referred to the MCAC. In any event, our goal is to make coverage decisions based on sound evidence of medical necessity in as expeditious a manner as possible.

With regard to concerns about our coverage of PET, we view this process as an example of how our commitment to work publicly with concerned parties can help us meet our goal. CMS has had town hall meetings, numerous presentations, and visits by advocates. As a result, we presently provide coverage of PET for certain of the following indications: solitary pulmonary nodule, non-small cell lung cancer, esophageal cancer, colorectal cancer, lymphoma, melanoma, head and neck cancers, myocardial viability, refractory epileptic seizures, and myocardial perfusion using Ru82 tracer. CMS is currently considering coverage of PET for thyroid cancer, soft tissue sarcoma, Alzheimer's disease, and myocardial perfusion using N-13 ammonia tracer.

CMS encourages the PET community to consult with experts in the evaluation of diagnostic technology in designing studies that will improve the empirical information available to clinicians and patients who use PET. CMS staff is also available to meet with scientists and clinicians involved in the development of novel technologies in order to provide general advice on study design. High quality studies that address clinical benefit will be the most efficient way for Medicare to continue to expand coverage for novel beneficial technologies in a time frame that better matches the pace at which they are being developed.

CMS treats PET no differently than MRA. Like PET, Medicare has covered MRA incrementally based upon the available scientific evidence.

It is important to note that a major aspect of our efforts on Medicare coverage has been directed at helping stakeholders and all interested parties understand the process and criteria that will be used in making coverage decisions. One clear distinction needs to be drawn between the process used by the FDA, which decides when a product can safely enter the marketplace, and that used by CMS, which moves beyond issues of safety to consider the matters of items and services that are reasonable and necessary for Medicare beneficiaries and the clinical utility of the item or service relative to clinical alternatives. CMS and FDA continue to increase the coordination

SUPPORTING INFORMATION

between the two agencies in an effort to improve consistency and decrease duplication.

Item

Access to Care--The Committee is aware of the joint activities of CMS and HRSA to improve access to medical and dental care for mothers and children in underserved populations. CMS and the Maternal and Child Health program at HRSA have worked together to assist States to reduce barriers to care for Medicaid and SCHIP populations for maternal and child health care including oral health care. The Committee urges these agencies to continue their partnership and expand support for State oral health systems grants and innovative demonstration projects for the prevention and early intervention of dental diseases in young children, State dental access summit meetings, and the National Maternal and Child Oral Health Resource Center. The Committee recognizes that such agency collaborations are instrumental for providing coordinated services that do not duplicate limited resources. (Page 176)

Action Taken or to be Taken

We agree that improving access to medical and dental care for underserved populations is an important mutual interest of CMS and HRSA. CMS believes that it is important to maintain such inter-agency partnerships and fully intends to continue collaboration with HRSA, and other agencies, on issues of shared interest.

Item

Guidance Document on Dental Care for Medicaid-Eligible Children--The Committee is concerned that CMS has not updated its State guidance document on dental care for Medicaid-eligible children in over 20 years. The Committee is aware that CMS has commissioned and received an update of The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guide from the American Academy of Pediatric Dentistry. This document is vital to ensuring that the States correctly implement EPSDT dental requirements and provide full coverage for all eligible children. Furthermore, the guidance will help States improve access to dental care by providing a better understanding of the dental workforce and financing system. The Committee strongly urges CMS to release a revised State guidance manual on dental care under the Medicaid/EPSDT program before January 1, 2003. (Page 176/177)

Action Taken or to be Taken

CMS had a contract with the American Academy of Pediatric Dentistry (AAPD) to revise the dental guide from the 1970's. The AAPD produced a revised guide as requested and CMS is currently reviewing the document. We intend to publish the guide as soon as the review and any necessary changes are complete, approximately February 2003.

Item

Total Body Orthotic Management for Non-Ambulatory Severely Disabled Nursing Home Residents--The Committee expects the Secretary to issue "L" Codes based on fair and reasonable reimbursement levels to cover Total Body Orthotic Management

SUPPORTING INFORMATION

for Non-Ambulatory severely disabled nursing home residents. Such treatment will be a medically prescribed device consisting of custom fitted individual braces with adjustable joints designed to improve function, retard progression of musculoskeletal deformity, or to restrict, eliminate or assist in the functioning of lower and upper extremities, pelvic, spinal, and cervical regions of the body. Such device will consist of individually adjustable braces that are attached to a frame which is an integral component of the device, and for which the individual braces cannot function or be used apart from the frame. This responds to a long-standing Committee concern about an unintended consequence of HCFA Ruling 96-1. While designed to crack down on fraud and abuse in the DME market on Part B Medicare reimbursement, this ruling also denied a highly specialized whole body orthotic treatment that dramatically improves the medical condition and quality of life for some severely disabled Medicare beneficiaries under full time care in nursing facilities. The Committee notes the May 2002, congressionally authorized GAO report entitled "Orthotics Ruling Has Implications for Beneficiary Access and Federal and State Costs" that identifies a substantial nursing home population that has been denied this care as a result of 96-1, but recommends that a restoration of such care be accompanied by appropriate controls, consistent with those established for existing "L" codes, that protect the integrity of the Medicare Program. The committee recognizes the need for these controls, but at the same time notes that beneficiaries have been without this treatment for over 5 years and urges CMS to expeditiously re-establish reimbursement measures for these services. (Page177)

Action Taken or to be Taken

We have reviewed the GAO report regarding HCFA Ruling 96-1 that is referred to in the Committee's statement on reimbursement for devices used to treat beneficiaries in nursing homes. After reviewing the report and giving the issue further consideration, we continue to believe that the ruling is appropriate.

We note the following:

- The GAO did not recommend that the ruling be changed; but if it were changed, program integrity concerns should be addressed.
- As indicated in the GAO report, the U.S. Court of Appeals decision in "Wardner v. Shalala" found that the content of the HCFA Ruling 96-1 was wholly supportable and that the ruling effectuated Congressional intent regarding the distinction between braces and durable medical equipment (DME).
- Also, as indicated in its report, the GAO, in general, agrees with CMS's comments on its report that rescinding the ruling could have a precedent-setting effect on the provision of certain types of equipment in skilled nursing facilities. The GAO report states that if the ruling were rescinded, the distinction between DME and orthotic devices would be blurred, making it more confusing for providers who are trying to bill appropriately and more difficult for DME carriers to identify and deny claims that were inappropriately billed.
- This ruling is important because it helps define DME accessories. The statute precludes separate Part B payment for DME accessories that are used in nursing

SUPPORTING INFORMATION

homes. These items are considered part of the nursing home's operating costs, and payment for them is included in the facility's basic inpatient rate. The nursing homes would then have the discretion to determine which manufacturer's products they choose to use.

After considering these issues, we believe that the changes to HCFA Ruling 96-1 would result in inappropriate and duplicative payments.

Item

Provider Education--The Committee encourages the Secretary to provide funding for HIPAA provider education geared specifically to home care and hospice providers. These funds should be used to assist providers in complying with HIPAA privacy and administrative simplification requirements.(Page 207)

Action Taken or to be Taken

CMS has initiated a number of outreach efforts that are dedicated towards educating rural and small providers, such as home health and hospice agencies, on the HIPAA administrative simplification requirements. In addition, the Department's Office for Civil Rights (OCR), which is responsible for overseeing the HIPAA Privacy Rule, has focused a significant portion of its efforts in this area on provider education, including home health care providers.

OCR has provided outreach and technical assistance at hundreds of health care conferences and has met with major health care groups to discuss implementation of the Rule. OCR is also developing a set of educational documents and videos tailored to the various segments of the health care community, as well as to consumers, describing their rights and responsibilities. These materials will address the specific information needs of health care institutions, such as rural and small hospitals, and providers such as home health care and hospice providers.

To provide a low-cost, widely accessible way for health providers to get oriented to HIPAA, CMS and OCR are hosting a series of national and regional teleconferences to provide an overview of HIPAA privacy and administrative simplification requirements and answer providers' questions. Thousands of providers have participated to date in these calls. In addition, CMS has:

- conducted outreach events in every State plus mailings and other activities;
- produced two informational videos -- distributed via satellite broadcast and mailings; and
- conducted a pilot of full-day HIPAA training session targeted at small rural providers in Mitchell, South Dakota. The next pilot is scheduled for early 2003 in Nebraska.

Since many small providers choose to use vendor products, tools, and services to achieve HIPAA compliance, CMS co-sponsored a vendor conference that was

SUPPORTING INFORMATION

designed to raise awareness and provide technical assistance to vendors who support providers and payers who need their HIPAA products.

CMS has also partnered with industry organizations to carry HIPAA administrative simplification messages to their members. For example, we have participated in audio casts sponsored by the American Hospital Association and the Medical Group Management Association to inform their members about the HIPAA extension deadline. We would be happy to contact the national homecare associations and arrange for either audio or video casts to further educate home health and hospice providers on the administrative simplification requirements of HIPAA.

Item

Hospital Payments-- The Committee directs the Secretary of Health and Human Services to review the Medicare Geographic Classification Review Board's criteria for reclassification determinations with respect to making payments to hospitals. The Committee requests the review to include a detailed analysis of disparities among hospital's reimbursement rates for hospitals in metropolitan statistical areas that border on areas that have a higher wage indices; the difficulty hospitals face in losing skilled medical personnel to neighboring areas with urban classifications and higher wage and salary structures; geographic and environmental impediments to traditional community routes; the base costs on which the wage index is applied; and the affect lower wage indices have on the quality of care. The Committee directs the Secretary to report to the Committee no later than January 15, 2003. (Page 177)

Action Taken or to be Taken

This Spring, the Office of Management and Budget will announce new metropolitan areas based on new criteria for determining whether a county should be considered metropolitan. These new metropolitan areas will be organized using data from the 2000 Census. In addition, we are in the process of collecting occupational mix data in response to the requirement of section 304 of BIPA 2000 that these data be collected by September 2003. During the next year we will be analyzing the impact of the new metropolitan areas and the occupational wage data on inpatient hospital payments. Once this evaluation is complete, we expect to begin using the new metropolitan areas and occupational wage data beginning October 2004.

Benefits Improvement And Protection Act Sections 521 And 522

In total, CMS requests \$129 million for processing Medicare appeals under Sections 521 and 522 of the Benefits Improvement and Protection Act of 2000 (BIPA), including the Administrative Law Judge function to be transferred from the Social Security Administration (SSA).

BIPA Section 521

BIPA section 521 significantly revises the Medicare fee-for-service appeals process. Key changes include a new reconsideration process conducted by qualified independent contractors (QIC), a uniform process for handling Part A and Part B appeals, a new right to an expedited appeal, much shorter time frames at all appeals levels, an “escalator” clause, and reduced amounts in controversy for Part B appeals.

CMS has proposed changes to the existing BIPA legislation. Our implementation plans and our budget request assume that the following changes will be enacted:

- Allow CMS 16 months, following the receipt of funding, to implement BIPA reforms. We estimate that 16 months is the appropriate amount of time needed to award contracts to QICs and to continue with rulemaking. CMS cannot begin the contracting process and make awards without funding.
- Enable CMS to contract with fewer than 12 QICs. We believe that 4 QICs will maximize administrative efficiency.
- Increase decision-making timeframes at all levels of the appeals process—from 30 days to 90 days for Part A appeals and from 30 days to 45 days for Part B appeals at the Medicare contractors; from 30 days to 60 days for QIC hearings; and from 90 days to 180 days for administrative law judge (ALJ) and Departmental Appeals Board (DAB) hearings. Although CMS supports BIPA’s goal of reducing processing times, we propose extending the timeframes to allow sufficient time to properly develop and adjudicate appeals. We are particularly concerned about the new “escalator clause” which allows beneficiaries to advance their appeal to the next level if a decision is not rendered by the statutory timeframe. This may result in appeals moving to a higher level only to be remanded back if no work has been done on them. More realistic timeframes should help improve the quality and efficiency of decisions, which will reduce the number of appeals filed at the higher, more costly adjudication levels.

CMS plans to contract with four QICs to process appeals and one QIC to act as a clearinghouse and coordinator. After contracts have been awarded, each QIC will require a 4 to 6 month start-up phase to hire and train staff, develop protocols, implement a data system, etc. The QICs would become operational in February, 2005.

SUPPORTING INFORMATION

CMS has proposed a \$50 filing fee for an appeal filed under the new QIC review process. This fee, which would apply to providers only, is expected to generate \$6 million in first-year collections in FY 2004. CMS would use these fees to develop an electronic, integrated case control system that would track appeals from the QICs through the ALJ hearing level. This system would allow for accurate record keeping and improve efficiency throughout these levels of the appeals process. This proposal would heighten provider awareness of the reformed processes as well as deter appeals submitted with inaccurate or incomplete information.

Medicare Hearings Workload: The Department and the Social Security Administration have agreed in principle to transfer the Medicare hearings function currently performed by SSA's Office of Hearings and Appeals. This request includes funds to effectuate this transfer. Medicare hearings are currently heard by SSA's administrative law judges (ALJ). Due to the current moratorium on hiring ALJs, CMS will need the authority to use administrative mechanisms other than ALJs, such as hearings officers, to conduct these hearings. The additional FTEs needed to process this work are not reflected in the totals shown throughout this document.

CMS assumes that the BIPA legislation will be amended to reflect the following:

- Both ALJ and DAB timeframes would be extended from 90 days to 180 days; and
- The BIPA requirement for a *de novo* review by the DAB would be changed in favor of an on-the-record review.

First-year costs of implementing BIPA 521 will be substantially lower than later years since it will take the QICs a few months to reach full processing capacity. CMS's first-year cost estimates also assume that the proposed legislative changes discussed above are enacted.

BIPA Section 522

Section 522 of BIPA creates a new administrative appeals process that enables certain beneficiaries to challenge national coverage determinations (NCDs) and local coverage determinations (LCDs). These administrative appeal rights are distinct from the existing appeal rights for the adjudication of Medicare claims. This section also creates additional avenues for beneficiaries to seek judicial review, after exhausting administrative appeal avenues.

CMS requests \$3 million to begin start-up activities in FY 2004 in preparation for implementing BIPA 522. These could include developing a document management system, providing training for the Medicare contractors, and beginning to hire and train staff needed to process and prepare NCD cases for DAB review. NCD's will be published on the Medicare website.



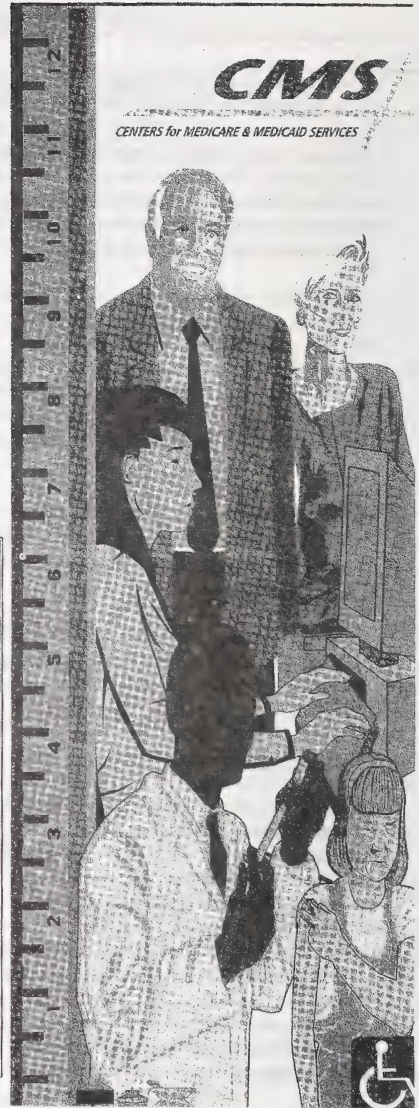
**Centers for Medicare &
Medicaid Services**

**FY 2004
GPRA Annual
Performance Plan**

**FY 2003 Revised Final
GPRA Annual
Performance Plan**

**FY 2002 GPRA Annual
Performance Report**

January 2003



**“WE ASSURE HEALTH CARE SECURITY
FOR BENEFICIARIES.”**

Mission Statement From
The Centers for Medicare & Medicaid Services

**For questions or comments on the CMS Annual Performance
Plan/Annual Performance Report, please contact:**

CMSAPP@cms.hhs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



Message from the Administrator

I am pleased to present the Centers for Medicare & Medicaid Services's (CMS) Annual Performance Plan (APP) and Report (APR) for fiscal year (FY) 2004, as required by the Government Performance and Results Act of 1993 (GPRA). The CMS takes great pride in the many achievements we are about to report on our programs and on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. Our approach to performance measurement under GPRA has been to develop an APP with goals that are representative of CMS's vast responsibilities.

The CMS has become the largest purchaser of health care in the United States, serving nearly 82 million Medicare and Medicaid beneficiaries. When the programs were established in 1965, Medicare was created as a means of providing affordable health insurance to the elderly (and later to certain disabled persons). Medicaid was conceived as a Federal/State partnership in policy setting and funding and as part of the social safety net for low-income persons.

The CMS's mission is to assure health care security for beneficiaries. For CMS, this has resulted in a strengthened Agency commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies. To ensure that CMS remains a responsive, dynamic, and relevant government agency that serves its citizens, we are focusing our attention on citizen-centered governance in FY 2004 and beyond. This APP and APR emphasizes this focus by identifying our significant processes and services, by helping us expand our resources in a way that enhances service to the public, by being accountable stewards of Agency resources, and by enabling us to monitor and evaluate our effectiveness. We will be communicating, collaborating, and cooperating with key customers, both public and private, to help us achieve the desired outcomes stated in this plan.

The 2001 President's Management Agenda gave CMS a great opportunity to develop initiatives to vigorously move the Agency forward with a focus on five primary objectives: integrating budget and performance; enhancing strategic management of human capital; increasing competitive sourcing; improving financial performance; and expanding electronic government. We are proud to announce that many of our performance goals are consistent with these objectives; in fact, of the 37 total performance goals represented in FY 2004, over 51 percent are focused on the President's Management Agenda.

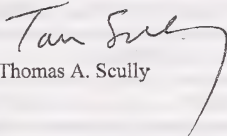
The CMS has met many challenges and demands but, overall, is reporting positive results in FY 2002. Although results for several of our 35 FY 2002 goals are still pending, we are encouraged by the results thus far (approximately 77 percent of our goals have reported with

Page 2 — Message from the Administrator

74 percent of those goals reaching their targets). In addition, the CMS has honored its agreement made with OMB during the Program Assessment Rating Tool (PART) process, and included two new program integrity goals in the FY 2004 plan. These new goals will measure our Medicare contractor error rate and Medicare provider compliance rate.

We have accomplished much in the past year and look forward to the challenges of the next year and beyond. The CMS is confident that performance measurement under GPRA will substantially improve CMS's programmatic and administrative performance. I am, therefore, pleased to report that the data measuring CMS's performance that are contained in this report are complete and reliable.

Sincerely,

A handwritten signature in dark ink, appearing to read "Tom Scully", with a long, sweeping horizontal line extending to the right.

Thomas A. Scully

 PERFORMANCE PLAN AND REPORT

EXECUTIVE SUMMARY	VI-1
AGENCY MISSION	VI-1
OVERVIEW OF PLAN AND PERFORMANCE REPORT	VI-2
I. OVERVIEW OF PERFORMANCE MEASUREMENT	VI-4
II. GOAL-BY-GOAL PERFORMANCE MEASUREMENT	VI-7
<i>Medicare Benefits</i>	<i>VI-8</i>
Performance Goal MB1-04	
Improve Satisfaction of Medicare Beneficiaries with the	
Health Care Services they Receive	VI-13
Performance Goal MB3-02	
Process Medicare+Choice Organization Elections in Compliance with	
the BBA Beneficiary Election Provisions	VI-17
Performance Goal MB4-04	
Improve Medicare's Administration of the Beneficiary	
Appeals Process	VI-20
<i>Quality of Care: Quality Improvement Organizations</i>	<i>VI-22</i>
Performance Goal QIO1-02	
Improve Heart Attack Survival Rates By Decreasing Mortality	VI-28
Performance Goal QIO2-04	
Protect the Health of Medicare Beneficiaries Age 65 Years and Older by	
Increasing the Percentage of Those Who Receive an Annual Vaccination	
for Influenza and a Lifetime Vaccination for Pneumococcal	VI-31
Performance Goal QIO3-04	
Improve Early Detection of Breast Cancer Among Medicare Beneficiaries	
Age 65 Years and Older by Increasing the Percentage of Women Who	
Receive a Mammogram	VI-34
Performance Goal QIO4-04	
Improve the Care of Diabetic Beneficiaries by Increasing the	
Rate of Diabetic Eye Exams	VI-37
Performance Goal QIO5-04	
Protect the Health of Medicare Beneficiaries by Optimizing the Timing of	
Antibiotic Administration to Reduce the Frequency of Surgical	
Site Infection	VI-39
<i>Quality of Care: Survey & Certification</i>	<i>VI-42</i>
Performance Goal QSC1-04	
Decrease the Prevalence of Restraints in Nursing Homes	VI-46
Performance Goal QSC2-04	
Decrease the Prevalence of Pressure Ulcers in Nursing Homes	VI-48
Performance Goal QSC3-04	
Improve the Management of the Survey and Certification Budget	
Development and Execution Process	VI-50
<i>Grants to States for Medicaid/Medicaid Agencies</i>	<i>VI-52</i>
Performance Goal MMA2-04	
Increase the Percentage of Medicaid Two-Year Old Children Who	
Are Fully Immunized	VI-57

PERFORMANCE PLAN AND REPORT

Performance Goal MMA3-02	
Provide to States Linked Medicare and Medicaid Data Files for Dually Eligible Beneficiaries.....	VI-60
Performance Goal MMA4-04	
Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates	VI-62
Performance Goal MMA5-04	
Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP).....	VI-65
<i>State Children's Health Insurance Program.....</i>	<i>VI-67</i>
Performance Goal SCHIP1-04	
Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid	VI-69
<i>Clinical Laboratory Improvement Amendments (CLIA)</i>	<i>VI-73</i>
Performance Goal CLIA1-03	
Sustain Improved Laboratory Testing Accuracy	VI-76
Performance Goal CLIA2-04	
Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver	VI-79
<i>Medicare Integrity Program.....</i>	<i>VI-81</i>
Performance Goal MIP1-04	
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program.....	VI-88
Performance Goal MIP2-03	
Develop and Implement Methods for Measuring Program Integrity Outcomes.....	VI-90
Performance Goal MIP3-01	
Improve the Effectiveness of Program Integrity Activities through the Successful Implementation of the Comprehensive Plan for Program Integrity	VI-92
Performance Goal MIP5-03	
Improve the Process of Credit Balance Recoveries.....	VI-100
Performance Goal MIP6-04	
Assess Program Integrity Customer Service.....	VI-103
Performance Goal MIP7-04	
Improve the Provider Enrollment Process	VI-105
Performance Goal MIP8-04	
Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Match Agreements with Insurers or Employers.....	VI-107
Performance Goal MIP9-04	
Reduce the Medicare Contractor Error Rate.....	VI-110
Performance Goal MIP10-04	
Improve the Medicare Provider Compliance Rate.....	VI-112

 PERFORMANCE PLAN AND REPORT

Performance Goal 27-00	
Reduce the Percentage of Medicare Home Health Services Provided for which Improper Payment is Made	VI-113
Medicare Operations.....	VI-115
Performance Goal MO1-04	
Improve Beneficiary Telephone Customer Service	VI-125
Performance Goal MO2-04	
Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements	VI-127
Performance Goal MO3-04	
Increase the Use of Electronic Commerce/Standards in Medicare.....	VI-129
Performance Goal MO4-04	
Maintain CMS's Improved Rating on Financial Statements	VI-132
Performance Goal MO5-04	
Improve CMS Oversight of Medicare Fee-for-Service Contractors.....	VI-134
Performance Goal MO6-04	
Increase Referral of Eligible Delinquent Debt for Cross Servicing	VI-136
Performance Goal MO7-02	
Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries in Fee-for-Service	VI-138
Performance Goal MO8-04	
Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries	VI-140
Performance Goal MO9-04	
Improve Beneficiary Understanding of Basic Features of the Medicare Program.....	VI-142
Federal Administrative Costs.....	VI-145
Performance Goal FAC2-04	
Develop and Implement an Information Technology Architecture.....	VI-153
Performance Goal FAC4-04	
Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice	VI-155
Performance Goal FAC6-04	
Improve CMS's Workforce Planning	VI-157
Performance Goal FAC7-04	
Improve CMS's Management Structure	VI-160
Performance Goal FAC8-04	
Strengthen and Maintain Diversity at all Levels of CMS	VI-163
Performance Goal FAC9-04	
Increase Awareness of the Opportunity to Enroll in the Medicare Savings Programs	VI-166
Performance Goal FAC10-04	
Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization.....	VI-169
Research, Demonstration, and Evaluation	VI-172
Performance Goal R1-04	
Assess the Relationship between CMS Research Investments and Program Improvements	VI-174

 PERFORMANCE PLAN AND REPORT

<i>Revitalization Plan</i>	VI-176
Performance Goal RP1-04	
Improve CMS's Information Systems Security	VI-179
PART III – APPENDIX TO THE PERFORMANCE PLAN	VI-182
A.1 LINKAGE TO HHS AND CMS STRATEGIC PLANS	VI-182
A.2.A CHANGES IN ANNUAL PERFORMANCE PLAN (APP) GOALS	VI-186
A.2.A CHANGES IN ANNUAL PERFORMANCE PLAN (APP) GOALS	VI-187
A.2.B REVISED FINAL FY 2003 GPRA ANNUAL PERFORMANCE PLAN GOALS	VI-190
A.3 PARTNERSHIPS AND COORDINATION	VI-200
A.4 DATA ISSUES – DATA VERIFICATION AND VALIDATION	VI-201
A.5 PERFORMANCE MEASUREMENT LINKAGES WITH BUDGET, COST ACCOUNTING, INFORMATION TECHNOLOGY PLANNING, CAPITAL PLANNING, AND PROGRAM EVALUATION	VI-202
A.6 DEVELOPMENTAL GOALS TIMELINE	VI-204
APPENDIX B	VI-209

PERFORMANCE PLAN AND REPORT

EXECUTIVE SUMMARY**AGENCY MISSION**

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the Department of Health and Human Services. The creation of CMS in 1977 brought together, under one leadership, the two largest Federal health care programs--Medicare and Medicaid. These programs coordinate and finance health care for elderly, disabled, and low-income persons. When the programs were established in 1965, Medicare was created as a means of providing affordable health insurance to the elderly (and later to certain disabled persons). Medicaid was conceived as a Federal/State partnership in policy setting and funding and as part of the social safety net for low-income persons. The CMS has become the largest purchaser of health care in the United States, serving nearly 82 million Medicare and Medicaid beneficiaries.

The CMS's mission is to assure health care security for beneficiaries. The CMS's Strategic Plan – currently being updated – is developed in conjunction with the Strategic Plan of the Department of Health and Human Services (HHS) and outlines our goals for achieving this mission. The CMS's internal strategic planning process, the HHS Strategic Plan, the enactment of the Government Performance and Results Act (GPRA), and other HHS and government-wide programs have all emphasized the themes of accountability, stewardship and a renewed focus on the customer.

For CMS, this has resulted in a strengthened Agency commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies. To ensure that CMS remains a responsive, dynamic and relevant government agency that serves its citizens, we are focusing our attention on citizen-centered governance in fiscal year (FY) 2004 and beyond. This Annual Performance Plan (APP) and Report (APR) emphasize this focus by identifying our significant processes and services, by helping us expand our resources in a way that enhances service to the public, by being accountable stewards of Agency resources, and by enabling us to monitor and evaluate our effectiveness. We will be communicating, collaborating, and cooperating with key customers, both public and private, to help us achieve the desired outcomes stated in this plan.

Our performance goals are linked to the HHS Strategic Plan goals and the newly revised CMS Strategic Plan.

Consistent with GPRA principles, CMS has focused on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. The Agency is confident that performance measurement under GPRA will substantially improve CMS's programmatic and administrative performance.

 PERFORMANCE PLAN AND REPORT

OVERVIEW OF PLAN AND PERFORMANCE REPORT**Accountability through Performance Measurement**

Senior management has shown support for the CMS performance measurement process. They have assumed overall responsibility for GPRA performance goals and have appointed responsible, accountable goal leads and contacts.

Strong technical support for performance measurement also exists within CMS. We have established a Performance Measurement Technical Advisory Group made up of methodology and program experts across the Agency who examine the technical appropriateness, feasibility, and measurability of each of CMS's GPRA performance goals.

The chart below shows the number of performance goals and targets within those performance goals from the beginning of the GPRA process to the present submission, and it includes reporting tallies as appropriate.

PROGRAM PERFORMANCE REPORT SUMMARY

	<u>Goals in Plan</u>	<u>Targets in Plan</u>	<u>Targets Reported</u>	<u>Targets Met</u>	<u>Unreported</u>
1999	18	22	22	20	0
2000	30	40	40	31	0
2001	33	54	52	40	2
2002	35	59	49	40	10
2003	36	58	N/A	N/A	N/A
2004	37	59	N/A	N/A	N/A

Summary of FY 2002 Successes

Overall, CMS experienced positive results in FY 2002. Of the 35 goals being reported for FY 2002, we have 8 goals for which we do not have complete data. We have met or exceeded expectations for 20 of the 27 goals for which we have complete data.

Summary of FY 2002 Performance Challenges

Although we are not reporting success in meeting 7 goals in their entirety, we have made significant progress. For example:

PERFORMANCE PLAN AND REPORT

- The FY 2002 target to increase the dollar amount of debt referred for cross servicing to 100 percent of eligible delinquent debt was not met. The CMS managed to refer approximately 92 percent of its eligible delinquent debt by the end of the fiscal year. The balance of the eligible debt will be referred in FY 2003.
- We did not meet our FY 2002 target to develop a model fraud rate program under the Comprehensive Error Rate Testing program because we did not receive the HCFAC funding to carry out this project. We may take another look at developing a fraud rate if funding is received in future fiscal years.
- We did not reach our FY 2002 target of a 5 percent fee-for-service error rate; however, we continued our success of maintaining the error rate at 6.3 percent. We will further reduce the error rate by continuing to focus our corrective actions on areas of vulnerability identified by the OIG. We believe that by aggressively addressing specific high-risk areas we will continue to be successful in reducing the fee-for-service error rate.
- Although we met our target to implement the PECOS program, we did not meet our target of publishing the regulation pertaining to establishing and maintaining billing privileges. A revised provider enrollment form is dependent upon release of the regulation. These items are currently in the clearance process and we expect to issue them in FY 2003.
- We were unable to meet our goal to measure performance in processing enrollments/disenrollments in compliance with the Medicare+Choice beneficiary election provisions of the BBA. Due to the passage of the Bioterrorism Preparedness Act of 2001 (enacted June 2002), the implementation of the lock-in provisions has been statutorily delayed until FY 2005. Because there will be no data to report in FY 2003 and FY 2004, this goal has been discontinued.
- We did not meet our target to send appeals data collection instructions to the Medicare+Choice Organizations (M+COs). The CMS refocused its approach in response to industry concerns about imposing additional workload on the M+CO plans. Therefore, in an effort to relieve the burden on the M+COs, the appeals data collection will now be obtained through Independent Review Entities (IRE).
- Although we met our target to set accuracy standards to improve beneficiary telephone customer service, we did not meet our target to measure accessibility and caller satisfaction. These measures were discontinued due to a shift in focus to nationwide implementation of a single 800 number for beneficiary inquiries.

Pending FY 2000 and FY 2001 Performance Goals

Results are now available from the following previously unreported goals.

 PERFORMANCE PLAN AND REPORT

Goals Met

- FY 2001 goal to decrease the prevalence of restraints in nursing homes by 10 percent.
- FY 2001 goal to maintain a “clean opinion” on CMS’s FY 2001 financial statement.
- FY 2001 goal to improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.
- FY 2001 target to increase lifetime pneumococcal vaccine rates.
- FY 2000 and FY 2001 goal to increase the number of women 65 and older who receive a mammogram (NHIS and Medicare claims data for 2000 and 2001, respectively).

Goals Not Met

- The FY 2000 goal to reduce the home health error rate.
- The FY 2000 goal to decrease the one-year mortality rate following hospital admission for heart attack.
- The FY 2001 goal to reduce the Medicare fee-for-service error rate to 6 percent.
- The FY 2001 goal to decrease the prevalence of pressure ulcers in nursing homes.
- The FY 2001 target to increase the annual influenza vaccination rate.

I. OVERVIEW OF PERFORMANCE MEASUREMENT

This Annual Performance Plan (APP) for CMS sets out specific performance goals for the Agency for FY 2004. It builds on previous APPs submitted to Congress and contains many enhancements. The CMS’s APP complements and supports the Agency’s FY 2004 budget, and is integral to it. In this Annual Performance Report (APR), CMS is reporting on Agency performance for its FY 2002 GPRA goals.

The Agency’s APP is divided by budget category as a means of integrating budget and performance. The Table of Contents provides an easy-to-read road map indicating how the programs and performance goals are organized in the plan. The GPRA goals identified under each of our 11 budget categories are representative of the vital activities CMS performs to fulfill its mission. Thus, the APP does not reflect every activity and challenge encountered by the Agency. Using a representative approach is consistent with guidance from GAO based on the nature of the Agency’s work.

Performance measurement results will provide a wealth of information about the success of CMS’s programs and activities, and CMS uses performance information to identify opportunities for improvement and to shape its programs. The use of GPRA goals also provides a method of clear communication of CMS’s programmatic objectives to our partners, such as national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term. We look forward to the challenges posed by our performance goals and are optimistic about our ability to meet them.

The President’s Management Agenda of 2001 announced several reform initiatives with the primary objectives of making the Government more citizen-centered, results-oriented,

 PERFORMANCE PLAN AND REPORT

and market-based. In response to the President's five management objectives, CMS developed initiatives to vigorously move the Agency forward with a focus on five primary objectives: integrating budget and performance; enhancing strategic management of human capital; increasing competitive sourcing; improving financial performance; and expanding electronic government. Many of our performance goals are consistent with these objectives, as illustrated later in the Plan.

Consistent with the President's Management Agenda, CMS's initiatives include process reengineering efforts, improved methods of working and management initiatives that will enable the Agency to implement its long-term goals and objectives. For example:

- In order to expand e-government, we continue to improve our popular "medicare.gov" website to make the most of technology for the growing number of beneficiaries who have access to the Internet. It is a critical tool for our GPRA goals to improve the dissemination and understanding of Medicare information. Also, CMS makes use of computer based training (CBT) to educate our workforce on systems security issues and other subjects. This training enhances productivity by allowing employees the flexibility of scheduling training based on their individual schedule and makes a better use of time for both the employee and the Agency. It also provides a way for the employee to refer back to familiar training tools if necessary.
- Several CMS performance goals address the Agency's need to better manage its "human capital" in order to achieve its mission. As represented by our GPRA goal to improve our workforce planning, CMS seeks to identify existing workforce competencies and to eventually conduct gap analyses between current and future requirements and existing workforce skills and knowledge. Through our workforce planning efforts, we have identified broad competency areas that need to be targeted for skill and knowledge gap reduction, including strengthening management and leadership. To address this, CMS has developed a Leadership and Management Development Strategy (LMDS) to strengthen and increase the effectiveness of the Agency's leadership. This strategy is represented in our Plan by our goal to improve management structure. There is also a strong business case for our goal to strengthen and maintain diversity at all levels of CMS. By building a workforce that mirrors the diverse population we serve, we improve our effectiveness. These "human capital" goals will enable CMS and the Department of Health and Human Services (HHS) to effectively implement its Strategic Plan and long-term goals and objectives through a more effective workforce.

We have embarked on a national ad campaign, which assists beneficiaries and their caregivers to become active and informed participants in their health care decisions. In the fall of 2001, we implemented a number of new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their choices. These included expanded access to customer service representatives at 1-800-MEDICARE, expanded

 PERFORMANCE PLAN AND REPORT

web-based capabilities to help consumers compare health plan choices, and a national ad campaign on the new choices and new ways to get information on CMS programs. We conducted a similar national ad campaign in Fall 2002 to continue our promotion of 1-800-MEDICARE and www.medicare.gov. These strategies support a number of our GPRA goals in this Annual Performance Plan.

The use of performance measures to improve health care quality in the Medicaid program has been primarily undertaken by State Medicaid agencies. At the national level, we do not have information on health care quality for the majority of Medicaid beneficiaries receiving care in non-institutional settings. Therefore, CMS is beginning to work with States to jointly explore a strategy for State and Federal use of performance measures that will improve health care delivery and quality for Medicaid and SCHIP populations using reliable and valid performance measures.

Summary of Plan and Report

The CMS's total number of FY 2004 goals is 37. We carried over the majority of the goals in the FY 2003 plan, with new targets appropriate for FY 2004 focusing on meaningful outcomes. We have included a new budget category, which represents our Revitalization Plan. Our goal to Improve CMS's Information Systems Security has been relocated to this section. In addition, the CMS has honored its agreement made with the OMB during the Program Assessment Rating Tool (PART) process, and included two new program integrity goals measuring our contractor error rate and provider compliance rate. This year we will be reporting on the status of 35 FY 2002 performance goals.

An improvement in this year's plan is the indication in the reporting charts of linkage between our plan and the Department's Strategic Plan goals. In the reference section of the reporting charts, a numeral has been added to indicate to which goal(s) in the Department's Strategic Plan our FY 2004 GPRA **outcome** goals are linked. Goals associated with the President's Management Plan are identified by the  icon, which is also found in the reference section. Also in this section, as appropriate, we noted "See FY 03 Revised Final" for changes in FY 2003 goals.

The CMS's FY 2004 plan reflects our continued efforts to strengthen our coordination with other organizations and to enhance data verification and validation. With respect to data issues, CMS has been careful to cite and describe data sources for each individual goal, as well as particular data concerns or limitations. Data issues are explored further in the Appendix, Section A.4.

Each of our GPRA goals is outlined with targets for each fiscal year. Some goal targets are labeled "developmental" goals. We include these goals in our plan to show our commitment to certain priorities while acknowledging the challenges of developing a specific, measurable goal.

 PERFORMANCE PLAN AND REPORT

II. GOAL-BY-GOAL PERFORMANCE MEASUREMENT

In this section, we present our report on CMS's performance for FY 2002, and goals planned for FY 2003 and FY 2004. The report and goals are organized by budget category, including our new Revitalization Plan budget category. We begin by describing the category and presenting a table summarizing our FY 2002 performance and FY 2003 and FY 2004 goals. A performance summary for each budget category follows, which is then followed by goal narratives for the performance goals in that budget category.

Each performance goal is displayed within the associated major budget category. In general, if the actions planned to improve performance are mainly funded out of a given budget category, that is the category associated with the performance goal. The funding levels shown are the total dollars enacted or requested for each budget category, of which only a portion may be funding the specific activities or interventions described in a performance goal.

The 37 individual goal narratives for FY 2004 contain the following sections:

- *Baseline:* the initial data reported for the starting point of reference includes the year of the baseline data;
- *Target:* the desired performance level we plan to accomplish;
- *Discussion:* the rationale for selecting the particular performance measure, pertinent background information, and activities/interventions under way or planned to accomplish the goal;
- *Coordination:* the extent to which CMS coordinates with other organizations, such as other Federal agencies, State agencies, local agencies, private entities, and advocacy organizations;
- *Data source(s):* a description of the data used for measuring progress toward the goal; and
- *Verification and Validation:* the means for ensuring the accuracy and reliability of the data source(s).

Note:

- We continue to reference some official CMS forms with the "HCFA" acronym, for example HCFA-1500. We are exercising fiscal restraint by exhausting our forms already on hand.
- The Medicare Peer Review Organizations (PROs) are now known as Quality Improvement Organizations (QIOs). All references have been changed accordingly.

MEDICARE BENEFITS

Medicare Benefits

Medicare Benefits	FY 2001 Actual*	FY 2002 Actual*	FY 2003 Current Estimate*	FY 2004 Estimate
Total Budget Authority	\$236.6 B	\$252.2 B	\$267.8 B	\$278.6

* Includes SMI transfer to Medicaid

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the Nation's largest health insurance program, which covers approximately 41 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For nearly four decades, this program has helped pay medical bills for millions of Americans, providing them with comprehensive health benefits they can count on.

Other representative goals related to this budget category but not listed in the chart are:

- Protect the Health of Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal (QIO2-04)
- Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram (QIO3-04)
- Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams (QIO4-04)
- Protect the Health of Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection (QIO5-04)
- Improve Beneficiary Telephone Customer Service (MO1-04)
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries (MO8-04)
- Improve Beneficiary Understanding of Basic Features of the Medicare Program (MO9-04)

MEDICARE BENEFITS

Performance Goals	Targets	Actual Performance	Ref.
Improve satisfaction of Medicare beneficiaries with the health care services they receive			MB1
--Managed care access to care	FY 04: 93% of beneficiaries FY 03: Collect (& share) data FY 02: Collect (& share) data FY 01: Develop new baselines/ targets to include disenrollee data FY 00: Collect/share data to achieve 79% of plans by CY 2003* FY 99: Develop target	FY 04: FY 03: FY 02: Data collected (Goal met) FY 01: 90.5% of beneficiaries (Baseline) (Goal met) FY 00: Data collected (Goal met) FY 99: Target dev. (Goal met) FY 98: 74% of plans* (Baseline)	3, 5
--Managed care access to specialist	FY 04: 86% of beneficiaries FY 03: Collect (& share) data FY 02: Collect (& share) data FY 01: Develop new baselines/ targets to include disenrollee data FY 00: Collect/share data to achieve 75% of plans by CY 2003* FY 99: Develop target	FY 04: FY 03: FY 02: Data collected (Goal met) FY 01: 83.7% of beneficiaries (Baseline) FY 00: Data collected (Goal met) FY 99: Target developed (Goal met) FY 98: 70% of plans (Baseline)*	
--Fee-for-service access to care	FY 04: 95% of beneficiaries FY 03: Collect (& share) data FY 02: Collect (& share) data FY 01: Develop baselines/ targets FY 00: Same as FY 1999 FY 99: Continue to develop measurement and reporting methodology	FY 04: FY 03: FY 02: Data collected (Goal met) FY 01: 92.8% of beneficiaries (Baseline) (Goal met) FY 00: Survey fielded in FY 2001 with baseline data available fall 2001 (Goal met) FY 99: Development continuing (Goal met)	
--Fee-for-service access to specialist	FY 04: 85% FY 03: Collect (& share) data FY 02: Collect (& share) data FY 01: Develop baselines/targets FY 00: Same as FY 1999 FY 99: Continue to develop measurement and reporting methodology	FY 04: FY 03: FY 02: Data collected (Goal met) FY 01: 82.8% (Baseline) (Goal met) FY 00: Survey fielded in FY 2001 with baseline data available fall 2001 (Goal met) FY 99: Development continuing with survey to be fielded in FY 2001 (Goal met)	
*later changed in FY 2001 Revised Final Annual Performance Plan			

MEDICARE BENEFITS

Performance Goals	Targets	Actual Performance	Ref.
Process beneficiary Medicare+Choice organization elections in compliance with the BBA beneficiary election provisions	FY 03: Goal discontinued (due to legislation) FY 02: Develop a target that measures performance in processing enrollments/disenrollments in compliance with the beneficiary election provisions of the BBA	FY 02: (Goal not met due to legislation)	MB3 See FY 03 Revised Final
Timely ("same month") processing of clean Medicare+Choice enrollments equal to the effective date on the transaction	FY 02: See new measure (BBA election provisions, above). FY 01: 98% FY 00: 98% FY 99: 98%	FY 02: N/A FY 01: 99.3% (Goal met) FY 00: 98.7% (Goal met) FY 99: 95.6% (Goal not met) FY 98: System updated with managed care enrollments the month following receipt of the transaction (Baseline)	MB4 See FY 03 Revised Final 5
Improve Medicare's administration of the beneficiary appeal process (Developmental)	FY04: --M+CO: Begin data collection --FFS: Developmental FY 03: --M+CO: Enhance data collection --FFS: Developmental FY 02: --M+CO: Issue OPL with reporting instructions --FFS: Evaluate data needs & capabilities FY 01: --Publish Operational Policy Letter (OPL) --Begin collecting baseline data FY 00: Have system in place for collection of managed care appeal data	FY 04: --M+CO: --FFS: FY 03: --M+CO: --FFS: FY 02: --M+CO: Reassessed data collection (Goal not met) --FFS: Evaluation complete (Goal met) FY 01: --OPL132 04/27/01 (Goal met) --Collection delayed (Goal not met) FY 00: Delayed due to burden to M+CO (Goal not met.) (Baseline developmental)	MB4 See FY 03 Revised Final 5

Performance Results Discussion

Assuring health care security for our beneficiaries is our primary mission. While all of our GPRA goals support this mission in some way, we have attempted to identify several key measures to represent the Medicare benefits budget category. We want to encourage choice in the Medicare beneficiary community for medical coverage while maintaining high-quality care, so it is important that we select goals that address a range of issues--administrative and care-related.

 MEDICARE BENEFITS

high-quality care, so it is important that we select goals that address a range of issues--administrative and care-related.

Beneficiary Satisfaction - Our multi-year efforts to improve beneficiary satisfaction with the health care received apply to both managed care and fee-for-service (FFS). In an effort to capture more complete information for the managed care portion, data from a managed care disenrollee survey is combined with survey data from current managed care enrollees. Baselines and targets have been recalculated to reflect this change. In order for the increases to be statistically significant, these are long-term targets with reporting due at the end of the 5-year period.

Our efforts to improve beneficiary satisfaction are ongoing by continuing to collect and share CAHPS information from beneficiaries. Specific presentations on the CAHPS surveys, from which these measures are developed, have been made to individual Medicare managed care plans, to Quality Improvement Organizations (QIOs) at meetings of the American Health Quality Association, and to beneficiaries on the Medicare Health Plan Compare website. In addition, we have established a website to provide further assistance to QIOs on issues related to FFS. We are currently developing a website for Medicare managed care issues to be available to QIOs and other researchers.

Timely Enrollment - While encouraging our beneficiaries to choose the health plan best suited for their needs, we want to ensure timely enrollment into managed care with no interruption in health care delivery or payment. Unfortunately, we fell short of our FY 1999 target. The managed care organizations (MCOs) were unfamiliar with the new enrollment timeframes. Also the data extraction technique included some inappropriate transactions in the counts, resulting in the percentages being lower than they actually should have been. The MCOs have since gained experience with the new enrollment timeframes, and the extraction technique has been improved to provide more accurate data. Thus, in FY 2000 and FY 2001, we met and exceeded our target of 98 percent. For FY 2002 our goal was to develop targets that measure performance in processing enrollments/disenrollments in compliance with the beneficiary election provisions of the BBA regarding lock-in provisions and plan benefit packages. However, due to the passage of the Bioterrorism Preparedness Act of 2001 (enacted June 2002), the implementation of the lock-in provisions has been statutorily delayed until FY 2005. Because there will be no data to report in FY 2003 and FY 2004, this goal has been discontinued.

Beneficiary Appeals - It is important that we address beneficiary appeals for both managed care and FFS programs in Medicare. For example, appeals in the managed care program usually relate to "access to care" while the appeals issue in the FFS program is usually nonpayment for service. In FY 2002 the M+CO appeals target was to send data collection instructions to the M+COs. However, in response to industry concerns about imposing additional workload on the M+CO plans, CMS decided to refocus its approach, thus it did not meet this target. The data collection will now be obtained through Independent Review Entities (IRE) alleviating any burdens to the M+COs. The FFS FY 2002 target was met by having the appeals data re-evaluated to determine future

MEDICARE BENEFITS

needs for improving the administration of this essential beneficiary protection. The CMS is now considering whether its data needs would best be served by a unified system that can incorporate and utilize both FFS and M+CO data.

 MEDICARE BENEFITS

Performance Goal MB1-04**Improve Satisfaction of Medicare Beneficiaries with the Health Care Services they Receive****Baselines (New for FY 2002-2004 Goals ¹):**

CY 2000 Managed care - (a) Getting needed care for illness or injury: 90.5 percent of beneficiaries enrolled in a Medicare managed care (MMC) plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: 83.7 percent of beneficiaries enrolled in a managed care plan reported that it was not a problem to see a specialist that they needed to see.

CY 2000 Fee-for-service (FFS) - (a) Getting needed care for illness or injury: 92.8 percent of beneficiaries enrolled in the original Medicare FFS (MFFS) health plan reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Access to a specialist: 82.8 percent of beneficiaries enrolled in the original Medicare FFS health plan reported that it was not a problem to see a specialist that they needed to see.

FY 2004 Targets: Same as FY 2002/2003.

FY 2003 Targets: Same as FY 2002.

FY 2002 Targets: **Managed Care** - Direct efforts to achieve by the end of CY 2004 for (a) Getting needed care for illness or injury: 93 percent of beneficiaries, and (b) Access to a specialist: 86 percent of beneficiaries. These efforts include: (1) continue to collect MMC-CAHPS and Disenrollee data and make available to Medicare managed care plans, Medicare Quality Improvement Organizations (QIOs) (formerly known as PROs) and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice. **FFS** - Direct efforts to achieve by the end of CY 2004 for (a) Getting needed care for illness or injury: 95 percent of beneficiaries, and (b) Access to a specialist: 85 percent of beneficiaries enrolled in the Original Medicare FFS health plan will report that it was not a problem to see a specialist that they needed to see. These efforts include: (1) continue to collect MFFS-CAHPS data and make available to Medicare QIOs and Medicare beneficiaries, and (2) assist in quality improvement initiatives and beneficiary plan choice.

Performance: Goal met. We continue to collect CAHPS data and assist in quality improvement initiatives by sharing data with plans, QIOs and beneficiaries toward meeting our ultimate target by the end of CY 2004.

FY 2001 Targets: Developmental. **Managed care** - Develop new baselines/future targets including data from disenrollee survey.

FFS - Develop baselines/future targets based on survey results.

Performance: **Managed care** - Goal met. New baseline and 5-year target measures (see above) were developed using data collected from both the MMC and Disenrollee CAHPS for 2000, regarding beneficiary access to care and specialists.

FFS - Goal met. Baselines and 5-year target measures (see above) were developed from 2000 data collected in Round 1 MFFS-CAHPS for 2000, regarding beneficiary access to care and to specialists.

¹ **Managed Care** - Data for beneficiaries who voluntarily disenrolled from their managed care plans became available in FY 2001 from the 2000 survey and were combined with Consumer Assessment of Health Plans Survey (CAHPS) data for current enrollees to get a more complete picture of plan performance.

FFS - Baselines established with Round 1 Medicare FFS (MFFS) CAHPS data from CY 2000.

MEDICARE BENEFITS

(Continued from previous page)

Baselines for FY 2000 Goal

Managed care without disenrollees - (a) Getting needed care for illness or injury: In 1998, in 74 percent of plans, at least 90 percent of beneficiaries reported that they could usually or always get care for illness or injury as soon as they wanted. (b) Ease of getting referral to a specialist: In 1998, in 70 percent of plans, at least 80 percent of beneficiaries reported that it was not a problem to get a referral to a specialist that they needed to see.

Fee-for-service (FFS) - Developmental. Baseline data will become available in FY 2001. The CAHPS FFS survey was fielded in Fall 2000.)

FY 2000 Targets: **Managed care** - Continue efforts to achieve by CY 2003, (a) in 79 percent of plans, at least 90 percent of beneficiaries report that they could usually or always get care for illness or injury as soon as they wanted, and (b) in 75 percent of plans, at least 80 percent of beneficiaries report that it was not a problem to get a referral to a specialist that they needed to see.

FFS - Targets will be established after baseline data become available in FY 2001.

Performance: **Managed care** - Our interventions to improve beneficiary satisfaction have continued with regard to encouraging health plans and the PROs to use CAHPS measures in their quality improvement efforts. In an effort to capture more complete data for this goal, input from disenrolled beneficiaries will be included in the CAHPS survey. Therefore, baselines and future targets will be recomputed.

FFS - We began collecting CAHPS FFS data in Fall 2000.

FY 1999 Targets: **Managed care** - Develop target.

FFS - Continue to develop measurement and reporting methodology.

Performance: **Managed care** - Goal met. Baseline and target developed.

FFS - Goal met. Development continuing with survey to be fielded in FY 2001.

Discussion: A fundamental goal is that beneficiaries are our primary customers and one of CMS's main reasons for being is to assure satisfaction in the experiences beneficiaries have in accessing care for illnesses and injuries when needed, including their access to care of specialists. In response to the need to standardize the measurement of and monitor beneficiaries' experience and satisfaction with the care they receive through Medicare, CMS developed a series of data collection activities under the Consumer Assessment Health Plans Surveys (CAHPS). The CMS fields these surveys annually to representative samples of beneficiaries enrolled in each Medicare managed care plan as well as those enrolled in the original Medicare fee-for-service plan and provides comparable sets of specific performance measures collected in CAHPS to Quality Improvement Organizations (QIOs), health plans, and beneficiaries through various means, including the National *Medicare & You* Education Program (NMEP).

Provision of CAHPS performance information assists beneficiaries in their health plan choices under Medicare. Annual development of specific performance measures also permits use of CAHPS as a tool for monitoring beneficiary experiences in and satisfaction with differing care delivery modes and in different regions of the country. Plan-specific measures provide direct incentives for managed care plans to improve performance and health services quality. FFS measures, reported by geographic area, assist in development of strategies to improve care quality through targeted interventions implemented either directly by CMS or through State Medicare QIOs and other partners.

 MEDICARE BENEFITS

The performance indicators and satisfaction measures disseminated through the NMEP also are part of a long-term strategy to monitor and evaluate the use of specific services provided through Medicare, and improve consumer satisfaction regarding the services received. The CMS conducts research on the use and understanding of these measures by beneficiaries as well as in the effectiveness of specific initiatives monitored by these measures in improving service quality. Our baselines for both managed care and FFS satisfaction are already fairly high. Given this type of survey for a large group of people and considering the unrelated factors that could influence responses, we know that a target of 100 percent satisfaction is unrealistic. Nonetheless, our targets are challenging and are set for a 5-year period in order for the percentage increases to be large enough to be statistically detected.

Coordination: The development and implementation of Medicare consumer assessment measures are coordinated by CMS's central and regional offices. Dissemination of information sets based on these measures is also coordinated through an array of Federal, State, and local agencies, and advocacy groups, including the Social Security Administration, the Administration on Aging, American Association of Retired Persons, National Association of Area Agencies on Aging, National Caucus and Center on Black Aged, National Asian Pacific Center on Aging, and other groups. The CMS also coordinates specific quality improvement activities and information dissemination through the QIOs and other partners.

Data Source(s): The Medicare CAHPS are a set of annual surveys of beneficiaries enrolled in all Medicare managed care plans and in the original Medicare fee-for-service plan. The CAHPS for managed care was fielded with a sample of 600 beneficiaries in each of over 250 managed care plans in Fall 2000, i.e. FY 2001. Data collection for managed care disenrollees (beneficiaries who voluntarily left their plans) began in Fall 2000 within the same managed care plans. This survey obtains information about the experience of beneficiaries in their former health plan. Data from this survey are combined with the information collected from current enrollees to obtain a more complete picture of plan performance.

Data collection in CAHPS-FFS began in Fall 2000 (FY 2001) with samples of 600 beneficiaries in 275 geographic areas nationally. Information comparable to that obtained from the MMC-CAHPS were available from the MFFS-CAHPS in FY 2001 and are available to beneficiaries and others on the Medicare Health Plan Compare web site. The Medicare managed care and the Medicare FFS CAHPS surveys consist of between 90-95 questions and have undergone extensive cognitive testing with Medicare beneficiaries. The information collected in the Medicare CAHPS is comparable to other CAHPS information collected in surveys of persons enrolled in commercial, i.e. non-Medicare health plans.

Verification and Validation: The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 2.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare

MEDICARE BENEFITS

beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response. More detailed plan-level and geographic-area CAHPS results are also checked for consistency with the experience and satisfaction data collected both on a national and regional basis annually in the Medicare Current Beneficiary Survey (MCBS). Although MCBS satisfaction questions do not match those in CAHPS on an item-by-item basis, several measures are similar enough to be used for consistency checking especially with regards to national trending of beneficiary experience.

MEDICARE BENEFITS

Performance Goal MB3-02

**Process Medicare+Choice Organization Elections in
Compliance with the BBA Beneficiary Election Provisions
(Discontinued after FY 2002)**

Baseline: Prior to CY 2002, there was no ability to track elections at the plan benefit package (PBP) level or to apply the lock-in provisions affecting enrollments/disenrollments.

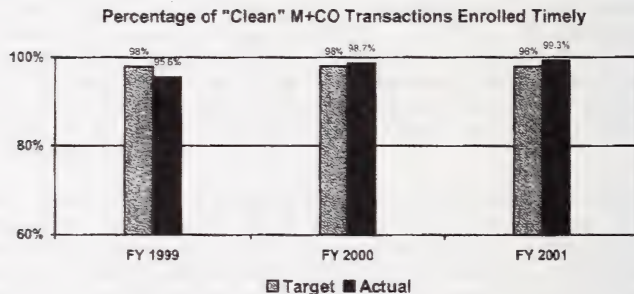
FY 2002 Target: Developmental. Develop a target that measures performance in processing enrollments/disenrollments in compliance with the beneficiary election provisions of the BBA.

Performance: Goal not met and discontinued due to legislation.

Baseline: In FY 1998, for clean* managed care plan enrollment transactions received in compliance with the monthly processing schedule (generally the first Tuesday or Wednesday of each month), the system updates beneficiary records with requested enrollment effective dates by the first of the following month.

FY 1999-2001: For 98 percent of clean* Medicare+Choice organization (M+CO) enrollment transactions received in compliance with the monthly processing schedule (generally the first Tuesday or Wednesday of each month), the system will update beneficiary records with enrollment effective dates equal to the effective dates on the transactions. (See chart below)

*clean = information submitted by M+CO is correct



Discussion: For FY 1999 through FY 2001, this performance goal measured the timeliness of CMS systems' processing of Medicare beneficiary enrollment transactions received from Medicare+Choice organizations (M+COs) as specified by the Balanced Budget Act of 1997 (BBA).

The performance goal for FY 2002 measured the processing of enrollment and disenrollment transactions received from M+COs in compliance with the beneficiary election provisions of the BBA effective in 2002. M+COs contracted with CMS to provide medical services to Medicare beneficiaries. In providing such services, M+COs

MEDICARE BENEFITS

could offer multiple plan benefit packages (PBPs) for members to elect. The BBA requires that beneficiary elections be tracked at the PBP level and also specifies time periods when beneficiaries may elect to enroll or disenroll from M+COs or to change PBPs. The CMS is maintaining PBP information for all members of M+COs for the first time in 2002.

The BBA requires that if a beneficiary wishes to make an election during an open enrollment period (OEP), he/she must do so in the first 6 months of CY 2002 or the first 6 months of Medicare eligibility (for new Medicare beneficiaries). In addition, only one election may be made during this timeframe. This election period is reduced in calendar year 2003 to 3 months. Elections are defined as enrollments and disenrollments into and out of a M+CO as well as PBP changes within an M+CO. These requirements are known as the lock-in provisions. There are some exceptions to these provisions related to special election periods (e.g., the beneficiary moves out of the M+CO's service area; the M+CO terminates).

To support these requirements, M+COs were to submit new data. In addition, since the lock-in provisions severely limited when such data could be submitted, it could only be accepted during certain times of the year. Currently, M+COs can submit enrollment/disenrollment data at any time. The CMS receives and edits M+CO transaction data for validity. The system ensures that each enrollee is a Medicare beneficiary and entitled to make an election.

The passage of the Bioterrorism Preparedness Act of 2001 (enacted June 2002) has statutorily delayed the implementation of lock-in provisions until FY 2005. As a result of this Act, beneficiaries are allowed to continue to enroll and disenroll on a monthly basis. However, CMS will require the reporting of the PBP Identifier and the Application Signature Date on enrollments, and on the new PBP election transaction code 71 to process PBP elections. M+COs will not report the type of election (i.e. Annual Election Period, Open Enrollment Period). Also, CMS will not implement the lock-in provisions, so election limits will not be counted or applied to any transaction. Given the impact of the Act on this activity, this goal is discontinued at this time.

Coordination: The CMS will coordinate its efforts with M+COs and beneficiaries. The improvements stated above are directly related to accurate submittals by M+COs. The CMS will reject noncompliant transactions and notify M+COs of errors. Beneficiaries will be informed about the election provisions so they are aware of the revised timeframes. In addition, as changes are made to the current system and/or as the new system modules become active, user-impacted changes will be communicated to the M+COs and training provided as necessary.

Data Source(s): The source of the data will be the Group Health Plan (GHP) system, which maintains enrollment and disenrollment information.

MEDICARE BENEFITS

Verification and Validation: The GHP system will be equipped with edits to verify PBP data and the election timeframes. A percentage will be developed based on preliminary data received during the last quarter of FY 2002.

MEDICARE BENEFITS

Performance Goal MB4-04

Improve Medicare's Administration of the Beneficiary Appeals Process

Baseline: Developmental. Baseline data collection for Medicare + Choice Organizations (M+CO) appeals will begin in FY 2002 and continue through FY 2003.
FY2004 Target: Developmental. M+CO: Begin collection of Independent Review Entity (IRE) data. FFS: Developmental
FY 2003 Target: Developmental. M+CO: Enhance data collection at the Independent Review Entity (IRE) level. FFS: Developmental
FY 2002 Target: Developmental. M+CO: Issue OPL with reporting instructions. Performance: Goal Not Met FFS: Evaluate CMS's FFS appeal data needs and capabilities. Performance: Goal Met
FY 2001 Target: Publish Operational Policy Letter (OPL) and begin collecting baseline data for M+COs. Performance: OPL published 04/27/2001, collection delayed.
FY 2000 Target: Implement system for collection of M+CO appeal data. Performance: Goal not met due to added burden to M+CO.

Discussion: The appeals process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denials of payment or service. Under fee-for-service (FFS) Medicare, beneficiaries have the right to appeal a denial of payment by a Medicare fiscal intermediary (FI) or carrier. This appeal comes after the service has been provided. The appeals process takes on added significance under the M+CO programs because these appeals may also involve pre-service denials of care, thus opening the possibility of restricted access to Medicare services.

M+CO Data Collection:

Starting in FY 1999, CMS required M+COs to collect aggregate level appeals data in order to report to beneficiaries upon request. The CMS captures data on appeals activities not resolved at the M+CO level and that have proceeded to a higher level of review by an independent CMS contractor. The CMS does not yet capture data on plans' internal appeals activity, due to concerns regarding burdening plans with increased reporting requirements.

Various methods of data collection have been discussed and abandoned in light of industry concerns that these methods would be too burdensome. In FY 2002, CMS determined that the need to collect data at the M+CO level required reassessment. In response to industry concerns, CMS decided to enhance the data collection at the Independent Review Entity (IRE) level. In late FY 2002, CMS met with the IRE to discuss further enhancements that can be made to the M+CO data it already receives.

The CMS met with representatives of the IRE to review enhanced data elements and finalize a report on CMS's data needs. The IRE would report to CMS via a new system

MEDICARE BENEFITS

that would incorporate both the FFS and M+CO systems. The IRE is also working with CMS to determine whether additional data elements are needed to assist them in their monitoring of M+CO.

FFS Data Collection: In FY 2001, CMS awarded a contract to analyze FFS data from FIs and carriers. These evaluative efforts have been undertaken to determine FFS future data needs. The contractor's initial findings were submitted to CMS in FY 2002. Late in FY 2002, the contractor submitted a draft business case analysis, which outlined both user and system requirements. The CMS staff reviewed the requirements and made comments, that were incorporated into a refined document. This document was used to provide guidance on future requirements. The CMS is now weighing the benefits of a system that can utilize both FFS and MCO data.

Combined M+CO/FFS Data Collection

In FY 2002, CMS reassessed its data needs and system/business requirements for both FFS and M+CO. The same contractor that analyzed the requirements for individual M+CO and FFS systems is also performing a Business Case Analysis (BCA) of the benefits of a combined system. The contractor has met with representatives of both the FFS and M+CO teams to discuss modifications to the BCA.

Coordination: The CMS has worked closely with the Center for Health Dispute Resolution (CHDR), health insurance industry representatives from the American Association of Health Plans, Blue Cross Blue Shield Association, the Health Insurance Association of America, and representatives from specific managed care plans. The CMS has also sought input from the beneficiary advocacy community (e.g. the American Association of Retired Persons, Consumer Coalition for Quality Health Care, National Senior Citizens Law Center).

Data Source(s): Aggregate M+CO appeals data will be reported by the M+CO to the IRE. The IRE will maintain data in its system and provide reports to CMS. The IRE ultimately will report data into the Medicare Appeals System (MAS). Aggregate FFS data are entered into the Contractor Reporting of Operational Workload Data (CROWD) system by FIs and carriers.

Verification and Validation: The CMS utilizes an Independent Validation and Verification (IV&V) contractor to evaluate the performance of the contractor providing deliverables.

 QUALITY IMPROVEMENT ORGANIZATIONS

Quality of Care: Quality Improvement Organizations

Quality Improvement Organizations	FY 2001 Actual	FY 2002 Actual	FY 2003 Current Estimate	FY 2004 Estimate
Total Budget Authority	\$110.9 M	\$382.8 M	\$716.1 M	\$99.6 M

Under the Quality Improvement Organization (QIO) program, formerly known as the Peer Review Organization (PRO) program, CMS contracts with 53 independent physician organizations (one in each State, D.C., Puerto Rico, and the Virgin Islands) to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. The QIO responsibilities are specifically defined in the portion of the contract called the Scope of Work (SOW). Each SOW is three years in duration and each SOW can vary the activities the QIOs perform. Funding patterns tend to vary substantially from year to year. The QIO program is funded directly from the Medicare trust funds, rather than through the annual Congressional appropriations process.

Quality improvement in nursing homes is a major focus of the QIOs under the 7th SOW. In fact, there was a nation-wide rollout of QIO nursing home activities in November 2002. There is also an increased emphasis for the QIOs to work with the stakeholders, including the State Survey & Certification agencies to improve care in the Nursing Home Quality Initiative. This initiative, which is an important step in CMS's comprehensive quality strategy, is a multi-prong effort that consists of (1) CMS's continuing regulatory and enforcement initiatives conducted by State survey agencies; (2) new and better consumer information on the quality of care in nursing homes; (3) community-based quality improvement programs offered by Quality Improvement Organizations; and (4) collaboration and partnership to leverage knowledge and resources. The QIOs will work with nursing home providers to improve performance on agreed upon measures and to implement quality improvement projects. See Survey & Certification Quality of Care budget section of our Plan for more information about the Nursing Home Quality Initiative.

The following goals from the Survey & Certification Quality of Care budget section of our Plan are related to this budget category but are not listed in the report below:

- Decrease the Prevalence of Restraints in Nursing Homes (QSC1-04)
- Decrease the Prevalence of Pressure Ulcers in Nursing Homes (QSC2-04)

QUALITY IMPROVEMENT ORGANIZATIONS

Performance Goal	Targets	Actual Performance	Ref.
Improve heart attack survival rates -- Lower the 1-year mortality rate for Medicare beneficiaries following hospital admissions for heart attack	FY 03: Goal discontinued FY 02: 27.4% FY 01: 27.4% FY 00: 27.4 %	01-02: Expect data 6/04 00-01: Expect data 6/03 99-00: 33.2% ♦ (Goal not met) (NEW DATA) 98-99: 32.3% ♦ 97-98: 31.8% ♦ 96-97: 31.1% ♦ 95-96: 31.2% ♦ (Baseline) (* revised from 31.4%) ♦ data not risk adjusted	QIO1 See FY 03 Revised Final
Increase annual influenza (flu) and lifetime pneumococcal vaccinations (MCBS) -- Flu -- Pneumococcal	FY 04: 72.5% FY 03: 72.5% FY 02: 72 % FY 01: 72 % FY 00: N/A FY 04: 69% FY 03: 67% ♦ FY 02: 66% FY 01: 63% FY 00: N/A ♦ Revised Target	FY 04: Expect data 12/05 FY 03: Expect data 12/04 FY 02: Expect data 12/03 FY 01: 67.4% (Goal not met) (NEW DATA) FY 00: 70.4% FY 99: 69.3% * FY 98: 68.5 %* FY 97: 67.1 %* FY 96: 65 % FY 95: 61 % FY 94: 59% (MCBS) (Baseline) FY 04: Expect data 12/05 FY 03: Expect data 12/04 FY 02: Expect data 12/03 FY 01: 63.3% (Goal met) (NEW DATA) FY 00: 62.7% FY 99: 61.7 %* FY 98: 56.1 %* FY 97: 50.9 %* FY 96: 44.1 % FY 95: 34.6 % FY 94: 24.6 % (MCBS) (Baseline) * includes community dwelling beneficiaries only	QIO2 1, 3 See FY 03 Revised Final
Increase rate of annual influenza (flu) vaccination (NHIS) ** Shaded area indicates goal based on previous data source.	FY 01: Switched to new data source. (see above) FY 00: 60% FY 99: 59%	FY 00: 64% (Goal met) FY 99: 66% (Goal met) FY 98: 64% FY 97: 63% FY 95: 58% FY 94: 55% (NHIS) (Baseline)	

QUALITY IMPROVEMENT ORGANIZATIONS

Performance Goal	Targets	Actual Performance	Ref.
Increase biennial mammography rates (National Claims History file)	FY 04: 52%♦ FY 03: 51.5%♦ ♦ Measure based on 2002 HEDIS®	03-04: Expect data 8/05 02-03: Expect data 8/04 01-02: Expect data 8/03 00-01: 51% (Baseline)	QIO3 1, 3
	FY 03: See Above FY 02: 52%* FY 01: 51%* *Measure based on 1999 HEDIS®	01-02: Expect data 8/03 00-01: 51.6 % (Goal met) (NEW DATA) 99-00: 50.5% 98-99: 49% 97-98: 45% (Baseline)	See FY 03 Revised Final
Increase biennial mammography rates (NHIS) ** Shaded area indicates goal based on previous data source.	FY 01: Switched to new data source (see above) FY 00: 60% FY 99: 59%	FY 01: N/A FY 00: 68.1% (Goal met) (NEW DATA) FY 99: 66.8% (Goal met) FY 98: 63.8% FY 94: 55% (NHIS) (Baseline)	
Improve the rate of biennial diabetic eye exams	FY 04: 69.2% FY 03: 68.9% FY 02: 68.6 % FY 01: 68.3 % (69.0% recalculated)	02-04: 01-03: Expect data Spring '04 00-02: Expect data Spring '03 99-01: 68.9% (Goal met) (NEW DATA) 98-00: 68.1% 97-99: 67.8% (Baseline) (*revised from 68.5%)	QIO4 1, 5
Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection	FY 04: 54.8% FY 03: 49.8%	FY 04: FY 03: FY 02: FY 01: 47.4% (Baseline)	QIO5 1, 5 See FY 03 Revised Final

Performance Results Discussion

Improving the quality of care for Medicare beneficiaries is one of our primary objectives. The CMS's GPRA goals reflect quality priorities both in prevention and adhering to quality standards and support the Department's strategic plan goals. Several of the QIOs' national quality priorities are reflected in our performance goals. These health conditions represent those that impact a large number of our beneficiaries and impose a significant burden on the health care system. For example, an estimated 780,000 surgeries are complicated by infection each year resulting in longer hospital stays, increased morbidity, mortality, and health care costs. Therefore, our new goal to prevent surgical site infections focuses on administering antibiotics in a timely manner before a surgical procedure.

Heart Attack Survival - The ambitious goal to increase the 1-year survival rate among beneficiaries who suffer a heart attack illustrates CMS's partnerships with the QIOs to help improve the quality of care for our beneficiaries. This nationwide effort focuses on implementing known successful interventions for properly treating heart attacks and preventing second heart attacks. The impact of these improvements may be especially dramatic in areas where providers have not fully introduced these lifesaving measures.

We did not meet our FY 2000 goal to decrease the one-year mortality rate to 27.4 percent among Medicare beneficiaries following hospital admissions for heart attack. In fact, the one-year mortality rate for heart attacks that occurred between August 1, 1999 and July 31, 2000 was 33.2 percent (an increase over the rate for the previous year of 32.3 percent). Based on this data and other recent trends, we do not expect to meet the FYs 2001 and 2002 targets.

There are a number of interventions that have been proven to be successful for increasing heart attack survival following a heart attack, and we have made use of these interventions in hospitals. However, recent data indicate that the number of deaths occurring within one year following hospitalization for heart attack is not decreasing. Many complex variables might have made significant independent contributions to the survival rate. We will continue to report our results through FY 2002 but we are discontinuing this goal beginning in FY 2003. The CMS will continue to encourage and monitor research in this area to determine what may be causing these disappointing trends.

Adult Immunizations - Our performance goals on adult immunizations (annual influenza and lifetime pneumococcal) are examples of CMS's promotion of preventive health. Complications arising from pneumococcal disease and influenza kill more than 30,000 people a year in the United States -- typically resulting in more deaths per year than for all other vaccine-preventable diseases combined. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination for pneumococcal pneumonia and annual vaccination for influenza.

In recent years, there have been flu vaccine shortages and distribution delays, which have impacted the delivery of immunizations. The inability to quantify the impact of these shortages to date reduces the confidence we have in achieving our targets for the affected years, and for reliably setting future targets. Also, data analyses from different sources point to an apparent leveling off of flu vaccination rates, and most recent data for pneumococcal vaccinations indicate that these rates are slowing down as well.

In FY 2001, 67.4 percent of all Medicare beneficiaries age 65 years and older reported receipt of an annual flu vaccine, and 63.3 percent reported receipt of a pneumococcal vaccine in their lifetime. While we exceeded our target to achieve a 63 percent lifetime pneumococcal vaccination rate, we did not meet our target to achieve an annual flu vaccination rate of 72 percent. This decrease in the influenza vaccine rate reflects the

QUALITY IMPROVEMENT ORGANIZATIONS

temporary shortage and distribution delays that affected the vaccine distribution in 2000 and 2001, which were beyond our control.

The CMS and the CDC are still actively addressing the unknown impact of the 2000 and 2001 flu vaccine shortages and delayed delivery on our adult immunization performance measures and are closely monitoring recent trends, especially given the growing number of challenges we face in achieving this goal. Our targets for FYs 2002 – 2004 have been set based on the recent trends. In light of recent trends for pneumococcal, we are revising our FY 2003 target to a more realistic target of achieving a 67 percent lifetime pneumococcal vaccination rate in Medicare beneficiaries age 65 years and older.

The CMS will continue to promote the receipt of annual influenza and lifetime pneumococcal vaccinations. We hope that the recent establishment of standing orders for flu and pneumococcal vaccinations in nursing homes, hospitals, and home health agencies will help to overcome some of the barriers that prevent patients from being immunized.

Mammography – The CMS's performance goal to increase the percentage of women Medicare beneficiaries age 65 and older who receive a mammogram is another illustration of our Agency's promotion of secondary prevention and increasing cancer survival through early detection. Performance measurement of mammography rates has served to focus resources within CMS for ongoing monitoring and improved performance.

Final 2000 NHIS data show that we surpassed our FY 2000 target of 60 percent of women age 65 and older to receive a biennial mammogram by reaching 68.1 percent (the FY 2000 target was measured using NHIS data). We are also pleased to report that we have surpassed our FY 2001 target of 51 percent of women age 65 years and older to receive a mammogram by reaching 51.6 percent. FY 2001 marks the first year CMS used Medicare claims data (National Claims History File) to measure this goal.

The CMS's FY 2001 and FY 2002 mammography targets are based on the 1999 Health Plan Employer Data Information Set (HEDIS®) measure for breast cancer screening. Recently, the National Committee for Quality Assurance (NCQA) revised their technical specifications for the breast cancer screening measure and reported the updated definition in the HEDIS® 2002 Technical Specifications. The revised indicator reflects changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening.

The CMS's revised mammography indicator is a more restrictive definition than is the current indicator. Reanalysis of biennial 2000-01 mammography data with this "HEDIS® 2002" mammography measure suggest a decrease of 0.6 percent of eligible female beneficiaries age 65 years or older with mammography services paid by Medicare. Consequently, future targets for CMS's mammography goal have been revised, beginning with FY 2003, to account for the more conservative estimates from the HEDIS® 2002

measure. Additionally, trends indicate diminished gains in the biennial mammography rate among women age 65 and older from 1997-98 to 2000-01.

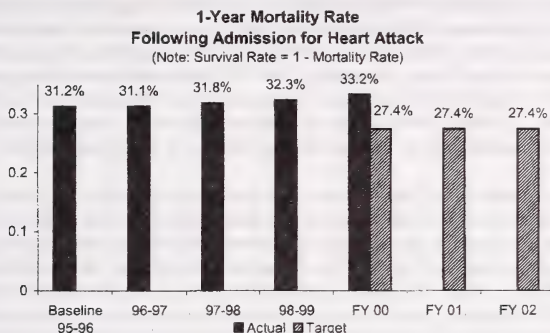
In late 2001-early 2002, there was a great deal of controversy in the press regarding mammography, along with press releases from governmental agencies affirming the recommendations for regular mammography screening. For example, the US Preventive Services Task Force (USPSTF) and the National Cancer Institute (NCI) continue to recommend mammography for early detection. Additionally, the Department of Health and Human Services issued a press release affirming the need for mammography screening. Continued outreach and education may be especially important at this time to ensure that women with Medicare get screening mammograms on a regular basis. The CMS remains committed to its mammography efforts.

Diabetic Eye Exams - Diabetes is another highly prevalent condition in the Medicare population. Many complications of the disease, such as blindness, can be prevented or delayed with appropriate monitoring and treatment. The CMS's quality goal to increase special eye exams for our diabetic beneficiaries reflects our commitment to improve diabetes care.

We surpassed our FY 2001 goal to increase the rate of biennial diabetic eye exams to 68.3 percent by increasing the rate to 68.9 percent. Based on the progress we have seen thus far, we anticipate continued success with this goal.

Surgical Site Infections - Optimizing the timing of antibiotic administration has been demonstrated to decrease the incidence of surgical site infection. The addition of this goal in our performance plan is another example of our commitment to preventive health and increasing healthy outcomes for our beneficiaries.

The Medicare Surgical Site Infection Prevention Project (SIP) is currently being implemented in 19 States and will be expanded nationally by February 1, 2003. While the SIP Project focuses on the five highest volume surgeries, CMS will only be targeting the total percentage increase in frequency from all the cases followed. Baseline data from 2001 demonstrated that antibiotics were only administered within the recommended timeframe in less than half (47.4 percent) the cases. With national expansion and continued QIO commitment our targets for FY 2003 and FY 2004 increase to 49.8 percent and 54.8 percent respectively, significantly reducing the number of complications our beneficiaries will experience.

Performance Goal QIO1-02**Improve Heart Attack Survival Rates
By Decreasing Mortality
(Discontinued after FY 2002)**

*Data not risk adjusted

The 1995-96 national baseline 1-year mortality rate among Medicare beneficiaries hospitalized for heart attack was 31.2 percent (corrected from previously-noted 31.4) based on hospital admissions for heart attack August 1995-July 1996. Rates calculated by CMS from Medicare Part A hospital claims and Medicare enrollment database.

Discussion: Improving treatment for heart attack has been a focus of CMS's Health Care Quality Improvement Program (HCQIP) since its inception in 1992. The CMS has been working to improve survival (by working to reduce deaths) from heart attack by assisting hospitals to improve their adherence to the following consensus-based treatment guidelines:

- Aspirin administered early in the hospital course (decreases clotting of the blood);
- Beta Blocker administered early in the hospital course (decreases heart's workload and oxygen need);
- Timely initiation of therapy to try to open blocked arteries in the heart (reperfusion therapy);
- Smoking cessation counseling during hospitalization;
- Aspirin prescribed at discharge;
- Beta Blocker prescribed at discharge; and
- Angiotensin Converting Enzyme (ACE) Inhibitor prescribed at discharge (reduces blood pressure) if the heart's pump function is impaired.

During the 1995-96 baseline period (August 1995 to July 1996) approximately 31.2 percent of Medicare beneficiaries hospitalized for heart attack died within a year. Since many patients were appropriate candidates for all or some of the treatments listed above, CMS anticipated that patient survival following a heart attack could be improved

 QUALITY IMPROVEMENT ORGANIZATIONS

by more widespread use of these proven therapies. The American College of Cardiology and the American Heart Association also initiated efforts to increase the use of these recommended treatments, all of which are included in their published guidelines.

Target rates for this goal were derived from data generated in a four-State pilot quality improvement effort conducted by Quality Improvement Organizations (QIOs) during 1994 through January 1995 to improve statewide rates focused on heart attack treatment. One-year mortality following heart attack was reduced by about one percentage point more than in other States. Starting in 1996, CMS expanded these efforts, and QIOs nationwide began to phase in quality improvement activities related to heart attack treatment. In 1999, CMS began writing performance-based contracts with QIOs, and we will be evaluating them on State-level improvement on these interventions.

The background rate of improvement in survival that occurred in the States not involved in the pilot project averaged about 0.6 percentage points per year. If this trend were to continue, the expected change after 5 years would be 3.0 percentage points. Therefore, the target assumed that this trend would continue; though this was somewhat uncertain and difficult to verify. A national intervention similar to the pilot project would be expected to improve 1-year mortality after heart attack by about 1 percentage point once the interventions had been widely adopted; all QIOs initiated these efforts by late FY 2000. Since approximately 323,000 Medicare beneficiaries are hospitalized for heart attacks per year (data from August 1995 through July 1996), a decrease of one percentage point would translate into about 3,000 lives saved.

There are a number of interventions that have been proven to be successful for increasing heart attack survival following a heart attack, and we have made use of these interventions in hospitals. However, recent data indicate that the number of deaths occurring within one year following hospitalization for heart attack is not decreasing. Many complex variables might have made significant independent contributions to the survival rate. We will continue to report our results through FY 2002 but we are discontinuing this goal beginning in FY 2003. The CMS will continue to encourage and monitor research in this area to determine what may be causing these disappointing trends.

Coordination: The CMS has worked with the National Heart, Lung, and Blood Institute, the American College of Cardiology, the American Heart Association, the American Medical Association, the American Hospital Association, and multiple other organizations during the foundational stages of these efforts, and continues its partnerships with a number of these organizations. The CMS will also continue its ongoing collaboration around HCQIP with the QIOs.

Data Source(s): The mortality rates are calculated from Medicare Part A hospital claims and the Medicare Enrollment Database. Since mortality data for the year following hospitalization are needed, there will be a lag in reporting results. For example, in order to know the 1-year mortality rate for patients hospitalized in August 2000 through July 2001, deaths occurring during August 2001 through July 2002 would need to be assessed.

QUALITY IMPROVEMENT ORGANIZATIONS

After updating the enrollment database, linking to the claims data, and performing the analysis, results would be expected in FY 2003. Neither the actual nor target rates have been adjusted for age or co morbidity, both of which may markedly affect the mortality rate.

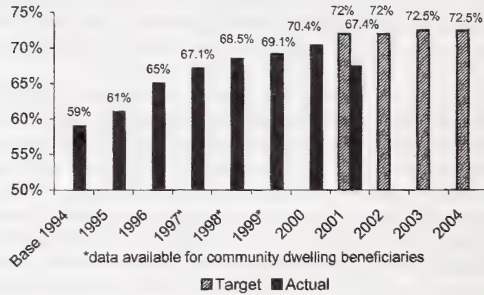
Verification and Validation: The Medicare eligibility file is derived from Social Security information, which is used as a basis for Social Security payments. Death data are validated against the National Mortality Index.

QUALITY IMPROVEMENT ORGANIZATIONS

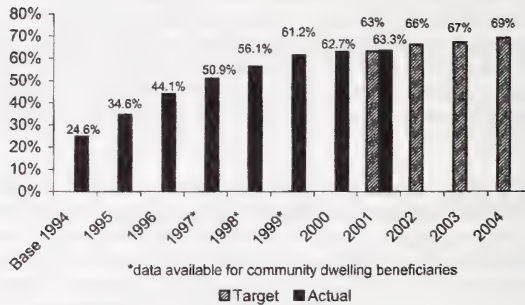
Performance Goal QIO2-04

Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal

Receipt of Influenza Vaccination Age 65 and Older (MCBS)



Receipt of Lifetime Pneumococcal Vaccination Age 65 and Older (MCBS)



Discussion: Complications arising from pneumococcal disease and influenza kill more than 30,000 people a year in the United States -- typically resulting in more deaths per year than for all other vaccine-preventable diseases combined. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination for pneumococcal pneumonia and annual vaccination for influenza. Consistent with the Department's strategic plan goals and

QUALITY IMPROVEMENT ORGANIZATIONS

through the collaborative efforts of CMS, the Centers for Disease Control and Prevention (CDC) and the National Coalition for Adult Immunization (NCAI), we are working to improve adult immunization rates in the Medicare population.

In recent years, there have been flu vaccine shortages and distribution delays, which have impacted the delivery of immunizations. The inability to quantify the impact of these shortages to date reduces the confidence we have in achieving our targets for the affected years, and for reliably setting future targets. Also, data analyses from different sources point to an apparent leveling off of flu vaccination rates, and most recent data for pneumococcal vaccinations indicate that these rates are slowing down as well.

Other challenges CMS faces in achieving our adult immunization goal include the following:

- The current reimbursement rate for vaccinations is considered too low by many providers, who are increasingly not offering this service;
- One of the largest manufacturers of influenza vaccines has recently dropped out of the market, with as yet unknown impact on production levels;
- Public concern about the general safety of immunizations has recently been fueled by reports of potential side-effects of the smallpox vaccine, with unknown consequences on compliance levels in our target population; and
- Pneumococcal vaccinations are still not universally accepted by providers.

The most effective strategy noted in current literature for improving patient access to adult immunizations is the implementation of standing orders. This occurs when non-physician personnel vaccinate according to a protocol without direct physician involvement at the time of immunization. To support this evidence-based intervention, CMS and the CDC have been working together to develop a strategy to increase the use of standing orders for influenza and pneumococcal vaccinations. In October 2002, standing orders were established for influenza and pneumococcal vaccinations in nursing homes, hospitals, and home health agencies that serve Medicare and Medicaid beneficiaries.

The CMS and the CDC are also still actively addressing the unknown impact of the 2000 and 2001 flu vaccine shortages and delayed delivery on our adult immunization performance measures and are closely monitoring recent trends, especially given the growing number of challenges we face in achieving this goal.

Our targets for FYs 2002 - 2004 have been set based on the recent trends. In light of recent trends for pneumococcal, we are revising our FY 2003 target to a more realistic target of achieving a 67 percent lifetime pneumococcal vaccination rate in Medicare beneficiaries age 65 years and older.

Coordination: The CMS, CDC and NCAI have formulated a long-term, structured campaign to increase the rate of influenza and pneumococcal vaccination among the Medicare population. One aspect of the campaign promotes the benefits of an annual

QUALITY IMPROVEMENT ORGANIZATIONS

influenza and lifetime pneumococcal vaccination directly to Medicare beneficiaries. This aspect of the campaign has been conducted via direct mail emphasizing Medicare coverage and the medical benefits of vaccinations. Another aspect of the campaign targets health care providers and focuses on interventions designed to minimize missed opportunities for immunization status assessment and vaccination.

Quality Improvement Organizations (QIOs) are working in collaboration with beneficiaries, providers, managed care plans, community groups and other interested partners to design and implement immunization quality improvement projects. These projects are conducted in hospitals, long-term care facilities, dialysis facilities, physician offices, home health agencies and public health clinics. They combine education for healthcare workers, a plan for identifying high-risk patients, and efforts to remove administrative and financial barriers that prevent patients from receiving the influenza and pneumococcal vaccines.

Data Source(s): In FY 2001, the Medicare Current Beneficiary Survey (MCBS) was designated as the primary data source for this goal. The MCBS is an ongoing survey of a representative national sample of the Medicare population, including beneficiaries who reside in long-term-care facilities.

The National Health Interview Survey (NHIS), an annual national household interview of non-institutionalized persons, was designated as the primary data source for this goal through FY 2000. Limitations to the continued use of the NHIS as the primary data source include: (1) time lags between collecting and reporting NHIS data, and (2) exclusion of Medicare beneficiaries who reside in long-term care facilities.

The NHIS and the Behavioral Risk Factor Surveillance System (BRFSS) provide comparable data to the MCBS, for community-dwelling persons age 65 or older, and will be used as secondary data sources

Medicare claims data (National Claims History file) provide another supplementary source of data but are likely to under-report vaccinations because the data exclude Medicare beneficiaries enrolled in managed care plans and beneficiaries who receive vaccinations outside the Medicare payment system (e.g., free clinics). Nevertheless, the information does provide great detail relating to demography, providers, geography, and vaccination opportunities missed.

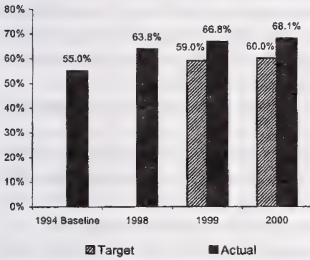
Verification and Validation: The MCBS uses Computer Assisted Personal Interview (CAPI) technology to perform data edits, e.g., range and integrity checks, and logical checks during the interview. After the interview, consistency of responses is further examined and interviewer comments are reviewed.

QUALITY IMPROVEMENT ORGANIZATIONS

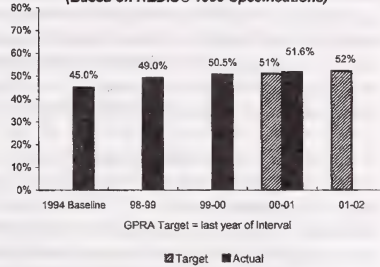
Performance QIO3-04

Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram

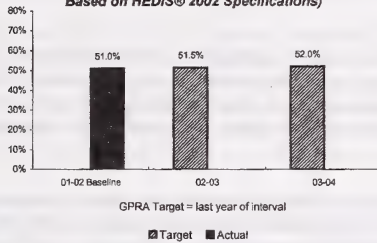
Receipt of Biennial Mammogram - Women Age 65 and Older (NHIS)



Receipt of Biennial Mammogram - Women Age 65 and Older (Medicare Claims) (Based on HEDIS® 1999 Specifications)



Receipt of Biennial Mammogram - Women Age 65 and Older (Medicare Claims) (Revised - Based on HEDIS® 2002 Specifications)



Discussion: CMS's National Medicare Mammography Campaign is directed at improving women beneficiaries' knowledge of breast cancer screening and awareness of Medicare's annual screening mammography benefit. Health care providers are also targeted to improve their recommendation of breast cancer screening.

In support of the Mammography Campaign, CMS's goal is to increase the percentage of Medicare women age 65 and over who receive a mammogram every two years. By taking advantage of the lifesaving potential of mammography, we hope to ultimately decrease mortality from breast cancer in the Medicare population. Women over 65 face a greater risk of developing breast cancer than younger women, and a disproportionate number of breast cancer deaths occur among older African-American women. Encouraging breast cancer screening, including regular mammograms, is critical to reducing breast cancer deaths for these populations. The enactment of the Balanced

 QUALITY IMPROVEMENT ORGANIZATIONS

Budget Act of 1997 expanded Medicare coverage to include annual screening mammograms for all Medicare eligible women effective January 1, 1998 and eliminated the part B deductible. Effective April 1, 2001, enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 expanded Medicare coverage to include digital mammograms.

The CMS's FY 2001 and FY 2002 mammography targets are based on the 1999 Health Plan Employer Data Information Set (HEDIS®) measure for breast cancer screening. Recently, the National Committee for Quality Assurance (NCQA) revised their technical specifications for the breast cancer screening measure and reported the updated definition in the HEDIS® 2002 Technical Specifications. Based on these recent revisions, we have modified our baseline and future targets, beginning with FY 2003, to attain consistency with the 2002 HEDIS® measure and to reflect changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening.

The CMS's revised mammography indicator is a more restrictive definition than is the current indicator. Analysis of the HEDIS® 2002 measure yields a mammography rate that is 0.6 percent lower for FY 2001 than is attained using our previous HEDIS® 1999 measure of eligible female beneficiaries age 65 years or older with mammography services paid by Medicare. Consequently, future targets for CMS's mammography goal have been revised, beginning with FY 2003, to account for the more conservative estimates from the HEDIS® 2002 measure. Additionally, trends indicate diminished gains in the biennial mammography rate among women age 65 and older from 1997-98 to 2000-01.

Coordination: The CMS has undertaken a National Medicare Mammography Campaign to increase awareness of the importance of regularly scheduled mammograms and the annual Medicare mammography benefit among Medicare women. This campaign relies on a variety of partnerships to reach both beneficiaries and providers with these important messages.

CMS's Mammography Campaign involves a number of components within the Agency, including the Center for Beneficiary Choices, the Center for Medicare Management and the Office of Clinical Standards and Quality, as well as CMS's contractors, the QIOs. In addition, the Campaign partners with a number of sister agencies with the Department of Health and Human Services including the National Cancer Institute (NCI), the Centers for Disease Control and Prevention, and the Public Health Service (PHS) Office of Women's Health. Researchers, physicians, and nurses are also consulted on a number of the mammography campaign activities.

The CMS's Quality Improvement Organizations (QIOs) are charged with monitoring and improving quality of care for Medicare beneficiaries. The QIOs are directed to improve mammography rates among female Medicare beneficiaries (in their respective States). The QIOs' contract performance will be evaluated, in part, on measured improvements in their statewide mammography rates. Among many of the mammography campaign activities, CMS and the QIOs have worked with Wal-Mart Stores, Inc. to distribute

QUALITY IMPROVEMENT ORGANIZATIONS

mammography educational materials to their pharmacy customers across the country. These educational materials - which include a Medicare message - are produced by CMS in partnership with the National Cancer Institute

Data Source(s): The National Claims History (NCH) file is the data source used to track the mammography goal. The percentage of women age 65 and older with paid Medicare claims for mammography services during a biennial period will be calculated. The denominator consists of women who are enrolled in both Part A and B on a fee-for-service basis. Medicare beneficiaries who are enrolled in an HMO for more than a month in either year of the biennial period will not be included in the rate calculation. The baseline of 45 percent for 1997-98 includes mammography services paid for by Medicare for women ages 65 and older that were not enrolled in managed care.

Secondary data sources include the Medicare Current Beneficiary Survey (MCBS), the National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS). The NHIS served as the primary data source for CMS's mammography goal through FY 2000.

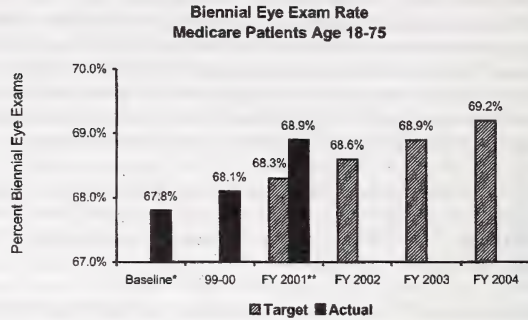
The CMS will continue to monitor recommendations by leading authorities such as the U.S. Preventive Service Task Force regarding the frequency of mammography and targeted age groups. As new developments dictate, CMS's staff will consider modifications to this goal to ensure consistency with evidence-based recommendations for mammography.

Verification and Validation: The NCH is a 100 percent sample of Medicare claims. Claims submitted by providers to Medicare are checked for completeness and consistency. Duplicates are eliminated to ensure that women who have more than one mammogram within the two-year period do not contribute to over counting. Mammography utilization rates for age groups, race and counties are calculated and compared to previous years' data to check for any unusual changes in data values.

The CMS will use these alternate data sources to verify and validate the reported trends that are based on the NCH. The self-reported rates of mammography screening have historically been higher when based on these survey sources. Therefore, we cannot directly compare the rates from the secondary data sources with the reported rate based on claims data, but will compare year-to-year changes observed in each data source, to determine if equivalent rates of improvement are seen.

QUALITY IMPROVEMENT ORGANIZATIONS

Performance Goal QIO4-04

Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams

* Baseline Revised from 68.5%

** FY 2001 target recalculated from 69.0%

Discussion: Diabetes is a major public health problem and is becoming more prevalent in all age groups. The increasing prevalence is attributed both to higher detection and to poorer health habits (increased rates of obesity being the primary culprit). According to the Centers for Disease Control and Prevention (CDC), prevalence of diagnosed diabetes increased in all age groups between 1980 and 1999, with people ages 65-74 years having the highest prevalence rate (14.51 per 100 population). The rate was 13 times higher than people less than 45 years of age (1.10 per 100 population). Among U.S. adults, diagnosed diabetes increased 40 percent from 1990 to 2000.

The National Eye Institute reports that diabetes affects approximately 14 million Americans, and about 40 percent of all people with diabetes have at least mild signs of diabetic retinopathy, the most common ocular complication of diabetes. Diabetic retinopathy is the leading cause of blindness in adults 25-74 years of age. People with diabetes are at a significantly higher risk of blindness than the general population. Up to 21 percent of newly diagnosed patients with Type 2 diabetes have retinopathy, and many develop some retinopathy over time. Screening and care can prevent up to 90 percent of diabetes-related blindness.

Coordination: The CMS has worked with the American Diabetes Association, the CDC, the Department of Veterans Affairs, the National Committee for Quality Assurance (NCQA) and many others in the development of this goal. The CMS has directed the Quality Improvement Organizations (QIOs) to improve the diabetic eye exam rate among Medicare beneficiaries in their respective States.

QUALITY IMPROVEMENT ORGANIZATIONS

The CMS has joined forces with the American Academy of Ophthalmology and the American Optometric Association to launch a national eye care campaign, which includes mailings to beneficiaries, a national outreach campaign with television star Bill Cosby as the spokesperson, and articles in popular and professional sources. Local QIOs have also contributed to the national campaign.

Data Source(s): The National Claims History (NCH) file will be the primary data source. The percentage of diabetics ages 18-75 with paid Medicare claims for a retinal exam during a biennial period will be calculated. An age range 18-75 was selected in order to be consistent with the Health Plan Employer Data Information Set (HEDIS®) comprehensive diabetes measure used widely in managed care. The denominator consists of diabetics who are enrolled in both Part A and B on a fee-for-service basis. Medicare beneficiaries who are enrolled in a health maintenance organization (HMO) for more than a month in either year of the biennial period will not be included in the calculation of the rate.

The biennial baseline is based on Medicare claims data for 2 million diabetic beneficiaries. The measurement period varied depending on an individual State's QIO contract cycle. Each State fell into one of three measurement periods. The first period covered calendar years: 1997 and 1998; second: April 1, 1997 - March 31, 1999; third: July 1, 1997 - June 30, 1999. Future biennial rates will be calculated in a similar manner. A programming error required a revision of the 1997-99 baseline from 68.5 percent to 67.8 percent.

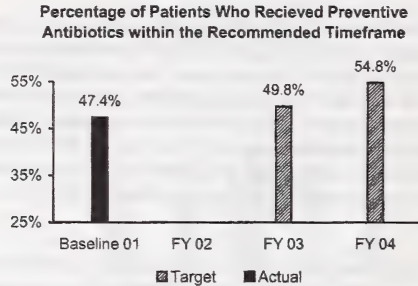
Secondary data sources include the NCQA HEDIS® data set and the NHIS. The NCQA HEDIS® data set is an annual survey of individual managed care plans. All Medicare+Choice plans are required to collect and report the rate of eye exams for their Medicare members who have diabetes. The NHIS is an annual national household interview of community-dwelling persons. The CMS will use these alternate data sources to verify and validate trends.

Verification and Validation: The NCH is a 100 percent sample of Medicare claims submitted by providers to Medicare and is checked for completeness and consistency. Utilization rates for age groups, race and gender are calculated and compared to previous years' data to check for any unusual changes in data values.

Medicare+Choice plans' HEDIS® data must be audited each year by an independent contract. These contractors implement a standard audit protocol that has been developed and tested by the NCQA, in conjunction with CMS. The NHIS is a validated survey which uses electronic data range checks and internal consistency checks.

QUALITY IMPROVEMENT ORGANIZATIONS

Performance Goal QIO5-04

Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection

Discussion: Postoperative surgical site infection (SSI) is a major cause of patient morbidity, mortality, and health care cost. SSI complicates an estimated 780,000 of nearly 30 million operations in the United States each year. For certain types of operation, rates of infection are reported as high as 20 percent. Each infection is estimated to increase hospital stay by an average of 7 days and add an average of over \$3,000 in hospital costs (1992 data). The incidence of infection increases intensive care unit admission by 60 percent, the risk of hospital readmission five-fold, and doubles the risk of death. Administration of appropriate preventive antibiotics just prior to surgery is effective in preventing infection.

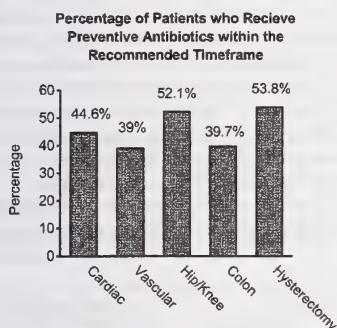
The goal of administering the antibiotic before surgery is to establish an effective level of the antibiotic in the body to prevent the establishment of infection during the time that the surgical incision is open. Studies performed in the 1960's and 1970's demonstrated that a common reason why the prevention failed was because the antibiotics were administered too far ahead of surgery (resulting in diminished antibiotic levels towards the end of surgery) or after the operation began (resulting in an absence of antibiotics towards the beginning of surgery). In a study of 2,847 surgery patients at The Latter Day Saints (LDS) Hospital in Salt Lake City, Classen, et al. found that the lowest incidence of post-operative infection was associated with antibiotic administration within one hour prior to surgery. The risk of infection increased progressively with greater time intervals between administration and skin incision. This relationship was observed whether antibiotics preceded or followed skin incision.

Opportunities to improve postoperative care have been demonstrated. The actual systems within hospitals are often the cause of improper antibiotic timing. For example, at LDS Hospital, administration of the first antibiotic dose "on call" to the operating room was frequently associated with the antibiotic being administered too early. Restructuring the

QUALITY IMPROVEMENT ORGANIZATIONS

system resulted in an increase in appropriate timing from 40 percent of cases in 1985 to 99 percent of cases in 1998.

The Centers for Medicare & Medicaid Services (CMS) has been developing the national Medicare Surgical Infection Prevention (SIP) Project, www.surgicalinfectionprevention.org, since 1999. The SIP Project measures the frequency of antibiotic administration within the hour prior to five common types of major surgery where infection is the most likely to occur (see below). The chart below shows the number of cases where antibiotics were administered within the hour prior to surgery compared to the number of cases followed (i.e. numerator/denominator). The data from FY 01 will be the baseline from which future years will be measured. While the data being collected have specific targets for the individual surgeries, CMS will only be reporting on the percentage of proper administration for the total of all five types of surgery.



Type of Surgery	# Patients receiving antibiotics within timeframe/ # of surgeries (baseline FY 01)
Cardiac	1556/3486
Vascular	561/1440
Hip/knee	3649/7000
Colon	944/2378
Hysterectomy	651/1211
Total	7361/15515

Coordination: The Centers for Disease Control and Prevention (CDC) has been a major partner in this project. The project will be implemented by the Medicare quality improvement organizations (QIOs) during the seventh contract cycle, which began for 19 States on August 1, 2002. The project will be implemented in all States by February 1, 2003.

The CMS and CDC have formed partnerships with 13 outside organizations to support the project. These include the American Academy of Orthopedic Surgeons, the American College of Surgeons, the American Geriatrics Society, the American Hospital Association, the American Society of Anesthesiologists, the American Society of Health Systems Pharmacists, the Association of Perioperative Registered Nurses, the Association for Professionals in Infection Control and Epidemiology, the Infectious Diseases Society of America, the Joint Commission on Accreditation of Healthcare Organizations, the Society for Healthcare Epidemiology, the Surgical Infections Society, the Voluntary Hospital Association, the Society of Thoracic Surgeons, and Premier, Inc. The Oklahoma Foundation for Medical Quality was contracted as the support QIO for the

QUALITY IMPROVEMENT ORGANIZATIONS

project. A SIP collaborative that applies the quality improvement methods of the Institute for Healthcare Improvement is in progress in all 50 States.

Data Source: Baseline State-level performance rates are calculated using data abstracted from up to 870 medical records sampled randomly in each State. Ongoing surveillance sampling will take place through the entire QIO contract period. Data are collected by two clinical data abstraction centers that have been under contract with CMS for 7 years. An abstraction tool designed specifically for that purpose will support data collection by hospitals.

Verification and Validation: The accuracy and reliability of data from the abstraction centers are monitored constantly through reabstraction of a sample of medical records. If the data collected by hospitals are used by CMS, the data will then be validated by each State's QIO and/or the clinical data abstraction centers.

SURVEY AND CERTIFICATION

Quality of Care: Survey and Certification
--

Survey and Certification Program	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Budget Authority	\$242.1 M	\$253.1M	\$247.6 M	\$247.6 M

The State Survey and Certification program ensures that institutions providing health care services to Medicare and Medicaid beneficiaries meet Federal health, safety, and quality standards. Institutions covered include hospitals, nursing homes, home health agencies (HHAs), end-stage renal disease (ESRD) facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries. The CMS's investment in quality oversight includes initial inspections of providers who request participation in the Medicare program, annual recertification inspections, and visits in response to complaints. The survey and certification budget includes funds to strengthen and continue activities focused on ensuring that our beneficiaries in nursing homes receive quality care in a safe environment. As part of CMS's Nursing Home Oversight Improvement Program, surveyors have been instructed to pay particular attention to nursing homes' use of physical restraints and to their ability to prevent and treat pressure ulcers. In addition, CMS's public reporting initiatives have provided new information to consumers about these measures. For example, the Nursing Home Compare website (www.medicare.gov/nhcompare/home.asp) gives consumers access to this information on the Internet.

Performance Goals	Targets	Actual Performance	Ref.
Decrease the Prevalence of Restraints in Nursing Homes	FY 04: 10% FY 03: 10% FY 02: 10% FY 01: 10% FY 00: 10% FY 99: 14%	FY 04: FY 03: Final Data expected 3/04 FY 02: Final Data expected 3/03 FY 01: 10.0% (Goal met) (NEW DATA) FY 00: 10.0% (Goal met) FY 99: 11.9% (Goal met) FY 96: 17.2% (Baseline)	QSC1 3,5
Decrease the Prevalence of Pressure Ulcers in Nursing Homes	FY 04: 9.5% FY 03: 9.5% FY 02: 9.5% FY 01: 9.6 % FY 00: Establish baseline/targets	FY 04: FY 03: Final Data expected 3/04 FY 02: Final Data expected 3/03 FY 01: 10.5% (Goal not met) (NEW DATA) FY 00: 9.8% (Goal met) (Baseline)	QSC2 3,5

SURVEY AND CERTIFICATION

Performance Goals	Targets	Actual Performance	Ref.
Improve the Management of the Survey and Certification Budget Development and Execution Process -- Use price based methodology to allocate survey and certification appropriation	FY 04: Allocate FY 2004 budget increase, at a minimum, to those States within the 15% threshold for unit survey hours for LTC and/or NLTC surveys FY 03: Allocate FY 2003 budget increase, at a minimum, to those States within the 15% threshold for unit survey hours for LTC and/or NLTC surveys FY 02: Allocate FY 2002 budget increase, at a minimum, to those States within the 15% threshold for unit survey hours for LTC surveys FY 01: Allocate FY 2001 budget increases to those States within the 15% threshold for unit survey hours	FY 04: FY 03: FY 02: (Goal met) FY 01: (Goal met)	QSC3 See FY 03 Revised Final 
-- Use performance measures and baselines to measure quality of survey work performed	FY 04: Assure FY 03 standards are met and identify appropriate corrective action plans FY 03: Assure FY 02 standards are met and identify appropriate corrective action plans FY 02: Evaluate FY 01 performance results FY 01: Develop measures	FY 04: FY 03: FY 02: (Goal met) FY 01: Measures developed (Goal met)	

Performance Results Discussion

The core of the nursing home survey process is a 4-5 day onsite visit that checks to see that a nursing home is meeting Federal health and safety requirements. The standard survey takes a "snapshot" of beneficiary care. They are unannounced and, by legislation, must take place based on a statewide average of once every 12 - 15 months. Also, States

SURVEY AND CERTIFICATION

must conduct complaint surveys within proscribed time frames any time a serious problem is alleged.

The CMS monitors specific data reported by nursing homes such as the Minimum Data Set (MDS) and the administrative data from the Online Survey Certification and Reporting System (OSCAR) and uses these aggregate data sets to provide a comprehensive view of the individual receiving care in the nursing home. State Survey and Certification Agencies focus on quality of care furnished to residents as measured by indicators of medical, nursing and rehabilitative care, dietary and nutrition services, activities and social participation, sanitation, infection control, and the physical environment. Our performance goals to improve the rates of physical restraints and pressure ulcers in nursing homes represent the Agency's commitment to protect its beneficiaries.

We know that targeted quality improvement initiatives improve the quality of care and Medicare Quality Improvement Organizations (QIOs) are leaders in these efforts. Quality improvement in nursing homes is a major focus of the QIOs under the 7th Scope of Work (SOW). In fact, the QIOs will be supporting CMS's efforts to publicly report the quality of care in nursing homes. The Nursing Home Quality Initiative is a multi-pronged effort that consists of 1) CMS's continuing regulatory and enforcement initiatives conducted by State survey agencies; 2) new and better consumer information on the quality of care in nursing homes; 3) community-based quality improvement programs offered by QIOs; and 4) collaboration and partnership to leverage knowledge and resources. QIOs will work with nursing home providers to improve performance on agreed upon measures and to implement quality improvement projects and will work with the stakeholders, including the State Survey & Certification agencies to improve care. Together, these activities will help us achieve our annual nursing home performance goals.

For now, CMS will maintain the targets for FY 2004 nursing home quality goals while we carefully assess trends and explore alternate measurement approaches for these goals.

Physical Restraints - The CMS's efforts to reduce the use of physical restraints through the State Survey and Certification Program have been successful. Use of restraints in nursing homes has decreased from 17.2 percent in 1996 to 10.0 percent in 2001, and we achieved our FY 2001 target. Although we have achieved a large reduction in the use of physical restraints in recent years, we believe that current program efforts are achieving smaller reductions in restraint use than they have previously. Interim FY 2002 data (September 2002) was 9.8 percent; final data for this goal is expected in early 2003. The CMS is exploring ways to further reduce physical restraints as we maintain the current target at 10 percent.

SURVEY AND CERTIFICATION

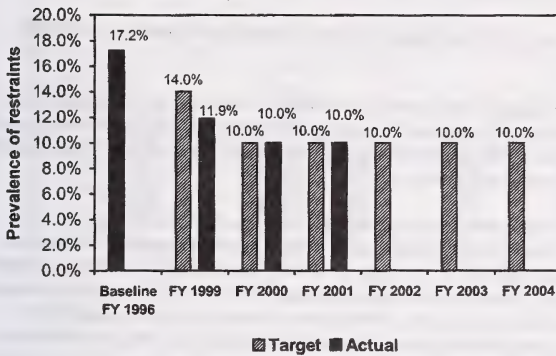
Pressure Ulcers – The CMS is concerned about the increase in pressure ulcer prevalence over the FY 2000 baseline and about the gap between the target and the measured rate. We did not meet our FY 2001 target of 9.6 percent, since reported rates were at 10.5 percent. The interim performance for FY 2002 is 10.4 percent (September 2002) against a target of 9.5 percent; final performance results will be available in early 2003. We believe that this increase in prevalence may stem in part from a number of factors: an artifactual effect due to facilities' change in coding behavior resulting in reporting of pressure ulcers that would not previously have been reported; and an increase in case-mix (severity of illness) of the nursing home population. We are working to better understand and address these variables. Also, we are developing a program to educate providers about more accurate assessment and coding, as well as new protocols aimed at onsite audit procedures that will verify the accuracy of nursing homes' Minimum Data Set (MDS) assessments. We are maintaining our target of 9.5 percent, as we reevaluate our future methodology for this performance goal.

Survey and Certification Budget – Our goal to improve the survey and certification budget process moved CMS from the "cost" based approach to a "price" based methodology, which uses national standard measures of workload and costs to project individual State workloads and budgets. The CMS met its FY 2002 target to allocate the FY 2002 budget increase to the State Survey and Certification budget using a price-based methodology. The CMS analyzed the combined national average survey times for long term care facilities. Any State that exceeded by 15 percent or more the combined national average survey time for long term care facilities was provided an FY 2002 base budget that assumed the FY 2001 funding level. All other States received a FY 2002 base budget increase proportionate to each State's FY 2001 budget. Also in FY 2002, CMS finalized its FY 2002 performance standards for State survey agencies.

SURVEY AND CERTIFICATION

Performance Goal QSC1-04

Decrease the Prevalence of Restraints in Nursing Homes



Discussion: "Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. According to the law, restraints can only be imposed to treat the resident's medical symptoms, to ensure safety and only upon the written order of a physician (except in emergency situations). Restraints should never be used for staff convenience or to punish the resident.

The reduction of the use of physical restraints is one of CMS's major quality initiatives. The prevalence of physical restraints is an accepted indicator of quality of care, and considered a quality of life measure for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. Many providers and consumers still mistakenly hold, however, that restraints are necessary to prevent residents from injuring themselves.

One of the main ways in which CMS can promote reduced use of physical restraints is through the State Survey and Certification Program. State and CMS surveyors who conduct annual inspections of nursing homes pay close attention to nursing homes' use of restraints and cite nursing homes for deficient practices when they discover that residents are restrained without clear medical reason.

In establishing performance goals for the quality area, CMS focused on measures that have been recognized as clinically significant and/or closely tied to care given to beneficiaries. Individuals in nursing homes are a particularly vulnerable population, and consequently, it is an area of considerable importance. A significant portion of benefit dollars in both Medicare and Medicaid pay for care in nursing homes. Although not yet updated for FY 2002, 19 percent of benefit dollars under Medicaid and nearly 6 percent

SURVEY AND CERTIFICATION

for Medicare were associated with nursing home expenditures in FY 2001. In the short term, CMS will continue to maintain a level target of 10 percent for restraints in Nursing Homes. We are evaluating possible effective interventions and measures.

Coordination: The CMS's coordination includes State survey agencies and CMS Regional Offices.

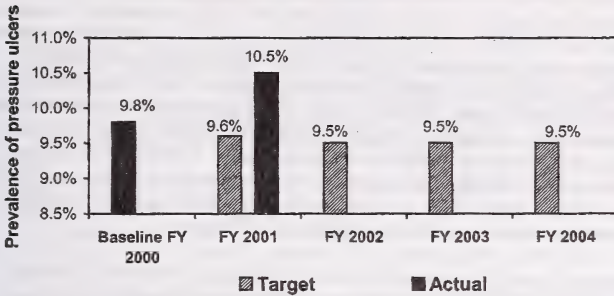
Data Source(s): Currently data on the use of physical restraints are contained in the Online Survey and Certification and Reporting (OSCAR) database. In the future, as the Minimum Data Set (MDS) information becomes more widely available, CMS plans to use these data to further refine this goal.

Verification and Validation: Data are verified during annual, onsite surveys. The measure used for this goal is the prevalence of restraint use at the time of the survey (OSCAR) and is self reported by the facility. During these surveys, surveyors perform resident observations, which include interviews and validation of the number of residents in restraints reported by the facility. During record review, surveyors identify the documentation of the medical symptom and the assessment and care plans associated with physical restraint use.

SURVEY AND CERTIFICATION

Performance Goal QSC2-04

Decrease the Prevalence of Pressure Ulcers in Nursing Homes



Discussion: "Pressure ulcer" refers to any lesion caused by unrelieved pressure resulting in damage to underlying tissues. The development of pressure ulcers is an undesirable outcome that can be prevented in most residents except in those whose clinical condition impedes the prevention of pressure ulcer development. Currently, CMS is in the process of revising and enhancing the interpretive guidelines for surveyors to include: adding information regarding the location of current clinical practice guidelines; enhancing the definitions related to pressure ulcer identification; providing an overview of current processes and practices for the prevention and treatment of pressure ulcers; and revising the investigative protocol for determining if pressure ulcer development was avoidable by the facility. In addition, after this information is in final form, it is planned that educational opportunities regarding the final products will be provided to both surveyors and providers utilizing nationally recognized clinical experts in pressure ulcer care. In addition, CMS is working with Quality Improvement Organizations (QIOs) to assist nursing homes with the development and evaluation of quality improvement programs to improve the prevention and treatment of pressure ulcers.

The prevalence of pressure ulcers in nursing homes appears to have decreased slightly from FY 2001 to 2002. The CMS is still concerned about the increase in pressure ulcer prevalence over the FY 2000 baseline and about the gap between the target and the measured rate. The interim performance for this goal is 10.4 percent against a target of 9.5 percent as of September 2002. Final performance results for the FY 2002 pressure ulcer target will be obtained in early 2003. The CMS believes that this increase in prevalence may stem in part from a number of factors, including facilities' change in coding behavior leading to their reporting pressure ulcers that would not previously have been reported and an increase in case-mix (severity of illness) of the nursing home population.

SURVEY AND CERTIFICATION

Reduction of facility-acquired pressure sores remains a high priority of the agency. There are a number of ongoing and planned initiatives that we think will lead to surveyors' improved identification of facility quality of care problems and that will help facilities improve their own quality of care. The CMS is developing a program to educate providers about more accurate assessment and coding of residents' conditions, including pressure ulcers. The CMS is also developing protocols, including onsite audit procedures, to assess the accuracy of nursing homes' Minimum Data Set (MDS) assessments. The CMS will continue to evaluate these data to determine whether or not they represent a true increase. For example, the CMS has developed a measure to track facility-acquired pressure ulcers to help differentiate pressure ulcers that develop in other care settings from those that develop in the nursing home. Additionally, CMS has convened a panel of national clinical experts in pressure sore treatment and prevention. These experts have helped CMS revise the interpretive guidelines and investigative protocols used by surveyors and to improve surveyor training.

Coordination: The CMS is actively pursuing participation of nationally recognized clinical experts on pressure ulcer care in our guideline development. The CMS is working with provider organizations, States, and consumer advocates in developing survey instruments and guidelines. In addition, as part of our effort to develop consistent scope and severity guidance, we have invited nationally recognized pressure ulcer experts from Yale University, and from the National Pressure Ulcer Advisory Panel to help us address pressure ulcer issues.

Data Source(s): The CMS will use the MDS, including special reports derived from the database, such as the quality indicator reports; to measure prevalence of pressure ulcers in long term care facilities. This information is submitted to the State MDS database and in turn is captured in the national MDS database. The measure being used for the pressure ulcer goal is one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison (CHSRA) that is derived from MDS assessments. For this goal we report the prevalence of pressure ulcers measured in the last six months of the fiscal year. If the year is not complete, we report the most recent data available. The numerator consists of all residents with a pressure ulcer, stages 1-4 on the most recent assessment and the denominator is all residents. Pressure ulcers counted on admission assessments are excluded.

Verification and Validation: MDS data quality assurance currently consists of reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.

SURVEY AND CERTIFICATION

Performance Goal QSC3-04

**Improve the Management of the Survey and Certification Budget
Development and Execution Process**

Baseline: Allocate funding based on previous year's costs.
FY 2004 Target: Allocate FY 2004 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care and/or non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.
FY 2003 Target: Allocate FY 2003 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care and/or non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.
FY 2002 Target: Allocate the FY 2002 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.
Performance: FY 2002 Target met for allocating FY 2002 Survey and Certification budget. The CMS finalized its FY 2002 performance standards for State survey agencies.
FY 2001 Target: Begin moving States towards a price-based methodology by allocating budget increases to those States with unit survey hours that do not exceed 15 percent above the combined national average, for long term care surveys. Allocate FY 2001 budget increases to those States that are within the 15 percent threshold, as appropriate. Develop performance measures and associated baselines that can be used to measure the quality of the survey work performed.
Performance: FY 2001 Target met for allocating FY 2001 Survey and Certification budget. Performance measures developed.

Discussion: The CMS's primary mission with the survey and certification program is to ensure that the nation's elderly and disabled are receiving high quality care. In order to ensure this high level of care, CMS has a responsibility to purchase high value survey services, verify that the survey services were performed as contracted, and assess the quality of the survey services performed. To accomplish these objectives, CMS moved from a cost-based budget development and execution model to a price-based model. A price-based methodology for developing and allocating survey and certification funding uses national standard measures of workload and costs to project individual State workloads and budgets, in order to move States towards more uniformity and efficiency.

To accomplish these objectives and to help ensure national consistency in the survey and certification budget process, CMS will continue to review and analyze State reported OSCAR 670 data in the area of survey hours reported for long term care facilities. For example, in FY 2002 CMS assumed the FY 2001 State funding levels as the budget base for States. Any increase to a State's FY 2002 base budget was contingent upon CMS's analyses of combined national average survey times for long term care facilities (skilled nursing and dually participating nursing facilities). Specifically, States that were within

SURVEY AND CERTIFICATION

15 percent or less of the combined national average survey time were provided with an FY 2002 base budget increase proportionate to each State's FY 2001 budget. Any State that exceeded the 15 percent combined average survey time threshold received a base budget that assumed the FY 2001 funding level.

The CMS will continue to update historical data with State reported Online Survey and Certification and Reporting (OSCAR) data. By focusing on average survey hours as the cornerstone of a price-based methodology, CMS will use national standard measures of workload and costs to project State workloads and budgets for FY 2003.

The CMS finalized its FY 2002 performance standards for State survey agencies. The CMS anticipates that updates to the performance standards will occur on an annual basis.

Coordination: The CMS's coordination includes Survey and Certification Oversight Board (SCOB), Center for Medicaid and State Operations (CMSO), Office of Financial Management (OFM), CMS Regional Offices (ROs), and State survey agencies.

Data Source(s): Workload data obtained from State reported OSCAR data and State Survey and Certification Workload Reports (Form HCFA-434). The budget, expenditure, and baseline data will be obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435) and from actual appropriated funding levels.

Verification and Validation: OSCAR data are validated annually as part of annual onsite surveys. Form HCFA-434 and Form HCFA-435 data are validated through CMS Regional Office reviews.

Medicaid Activity	FY 2001 Actual	FY 2002 Actual	FY 2003 Current Estimate	FY 2004 Estimate
Budget Authority	\$129.4 B	\$147.3 B	\$162.4 B	\$176.8 B

Another representative goal related to this budget category but not listed in the chart below is:

- | Performance Goal | Targets | Actual Performance | Ref. |
|--|--|---|--------------------------------|
| <p>Increase the Percentage of Medicaid Two-Year Old Children Who are Fully Immunized (Developmental)</p> <p>-- Group I</p> | <p>FY 04: 3-year reporting period complete</p> <p>FY 03: Measure State-specific immunization rate-Achieve State target</p> <p>FY 02: Measure State-specific immunization rates</p> <p>FY 01: Measure State-specific immunization rates</p> <p>FY 00: Complete development of State-specific methodologies and baselines</p> | <p>(See Appendix B)</p> <p>FY 04: N/A</p> <p>FY 03:</p> <p>FY 02: 12 of 16 States have reported second remeasurement. (See Appendix B)</p> <p>FY 01: All methodologies, baselines and targets set. 15 of 16 report first remeasurement. (See Appendix B.)</p> <p>FY 00: 16 of 16 States completed methodologies and baselines. (See Appendix B)</p> <p>FY 99: Identified Group I States and began developing State-specific methodology and baselines</p> | <p>MMA2</p> <p>1, 7</p> |

MEDICAID

Performance Goal	Targets	Actual Performance	Ref.
-- Group II -- Group III	FY 04: Measure State-specific immunization rate FY 03: Measure State-specific immunization rate FY 02: Measure State-specific immunization rate FY 01: Establish State-specific baselines and targets FY 00: Identify; begin developing State-specific methodologies and baselines FY 04: Measure State-specific immunization rate. FY 03: Measure State-specific immunization rate. FY 02: Establish State-specific baselines and targets FY 01: Identify; begin developing State-specific methodologies and baselines FY 00: N/A	FY 04: FY 03: FY 02: 5 of 10 States have reported first remeasurement. (See Appendix B) FY 01: 10 of 10 States complete methodologies and all have reported baselines and targets (See Appendix B) FY 00: Identified Group II States and began developing State-specific methodology and baselines FY 04: FY 03: FY 02: 17 of 24 States complete methodologies and have developed baselines and/or targets. (See Appendix B) FY 01: Group III States identified; began developing State-specific methodologies and baselines FY 00: N/A	
Provide to States Linked Medicare and Medicaid Data Files for Dually Eligible Beneficiaries	FY 03: Goal not continued FY 02: 56 States/ Territories FY 01: 56 States/ Territories FY 00: 56 States/ Territories FY 99: 27 States	FY 03: N/A FY 02: 56 States/Territories (Goal met) FY 01: 56 States/Territories (Goal met) FY 00: 56 States/Territories (Goal met) FY 99: 27 States (Goal met) FY 98: 12 States (Baseline)	MMA3

MEDICAID

Performance Goal	Targets	Actual Performance	Ref.
Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates.	FY 04: Pilot test the finalized CMS PAM Model in up to 25 States and develop final specifications for the model. FY 03: Expand the project to 12 States; pilot test the CMS PAM Model in all 12 States. Assess the results of the FY 02 pilot study; develop draft final specifications for the CMS PAM Model to be pilot tested in FY 04. FY 02: Pilot study in 9 States. FY 01: Pilot study in 2 States.	FY 04: FY 03: FY 02: (Goal met) FY 01: (Goal not met) Baseline: To be determined	MMA4 8 
Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) — Medicaid	FY 04: (a) Refine data submission, methodological processes, and reporting; (b) Produce 2002 performance measures in standardized reporting format; and (c) Collect 2003 data (baseline) from States. FY 03: To begin working with States on the PMPP. (a) Report on results of the meeting with States and identify a timeline for implementing recommendations; (b) Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; and (c) Initiate action steps for implementing recommendations.	FY 04: FY 03:	MMA5 See FY 03 Revised Final 5

 MEDICAID

Performance Goal	Targets	Actual Performance	Ref.
-- SCHIP	FY 04: (a) Refine data submission, methodological processes, and reporting; (b) Produce 2002 performance measures in standardized reporting format; and (c) Collect 2003 data (baseline) from States. FY 03: To begin working with States on the PMPP. (a) Report on results of the meeting with States and identify a timeline for implementing recommendations; (b) Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; (c) Initiate action steps for implementing recommendations; and (d) Begin to implement core SCHIP performance measures.	FY 04: FY 03:	

Performance Results Discussion

Childhood Immunizations - Despite significant challenges, there continues to be real progress in our State partnerships to increase childhood immunization rates for Medicaid two-year olds. The CMS continues to help States focus on this at-risk population by assisting them in developing State-specific measurements of childhood immunization.

Fifty of the fifty-one States eligible to participate in this project continue to work actively to increase the immunization rates of Medicaid two-year old beneficiaries. Maintaining the parameters of the project over five years, as established by each State, is not easily accomplished. Many States have encountered difficulty in continuing their methodologies and have had to find ways to resolve these issues to stay in the project. However, we believe that measuring States' performance through this project has affected immunization rates by providing an opportunity to draw attention to poor immunization rates in some States and focus them on improvement. In States where immunization rates are high, this project validates and highlights their current efforts and gives them an opportunity to continue successful interventions and plan additional interventions to maintain or improve their rate.

Fiscal year 2002 results thus far indicate 75 percent of Group I States reported second remeasurements, 50 percent of Group II States reported first remeasurements and 71 percent of Group III States reported their baselines and/or targets. Details on Group I, II and III States can be found in Appendix B. This Appendix summarizes each State's methodology, relevant definitions, numerical baselines, 3-year targets, and interim remeasurements.

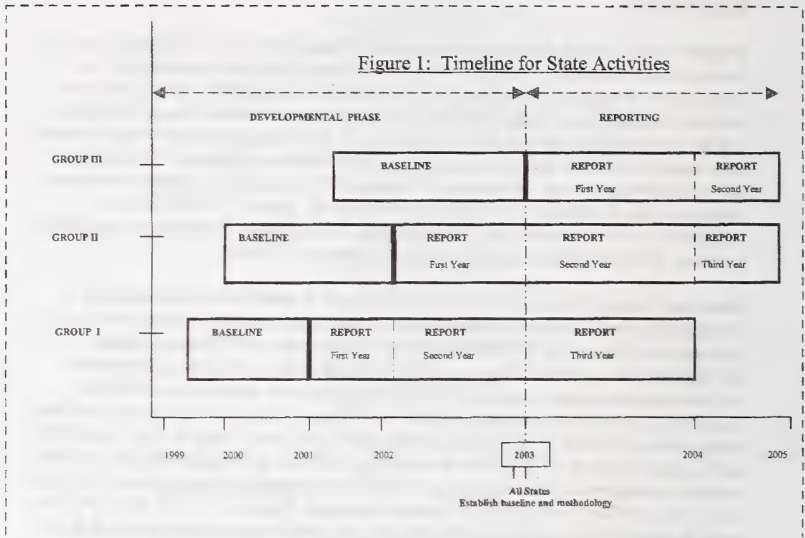
Provide States Linked Medicare and Medicaid Data - The aim of our goal to provide States linked Medicare and Medicaid data files for dually eligible beneficiaries is to enable States to analyze linked Medicaid and Medicare information. In FY 2002, we provided identifiers and made Medicare utilization data available to States. The States will do their own linking with their Medicaid files. This change enables States to match more current Medicaid data rather than use the State Medicaid Research Files (SMRF) that can lag behind two to three years. We met our FY 2002 goal by making Medicare utilization data available to 50 States and 6 Territories. Since FY 1999 CMS has successfully linked Medicare and Medicaid data, and has made Medicare data available to States. The CMS discontinued this goal beginning in FY 2003.

Medicaid Payment Error Rate - The FY 2002 goal to assist States in conducting Medicaid payment accuracy studies seeks to measure and ultimately reduce Medicaid payment error rates. Our FY 2002 target was to work with nine States to conduct payment accuracy studies. The data from these studies would be used to help refine payment accuracy measurement (PAM) methodologies and assess the feasibility of constructing a single methodology usable by all States. The actual pilot studies are being conducted in FY 2002. The CMS contracted with The Lewin Group to work with CMS and the pilot States in FY 2002 and are helping to develop promising Medicaid payment accuracy measurement methodologies for field testing in twelve States during FY 2003. The CMS and The Lewin Group will assess the results from the FY 2002 nine State pilot study and collaborate with the twelve States in FY 2003 in order to develop draft final specifications for the CMS PAM Model to be pilot tested in up to twenty five States in FY 2004.

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) - The CMS is developing a goal to establish formal Federal-State collaborations for improving health care delivery and quality for Medicaid and SCHIP populations using performance measures. In FY 2002, CMS met with States to jointly explore a strategy to effectively use performance measures to quantify and stimulate measurable improvement in delivering quality health care. In FY 2003 we are planning to establish a formal process to develop evidence-based Medicaid health improvement priorities (including performance measure specifications and targeted improvement models). Also in FY 2003, we are planning to implement performance measures in the Medicaid and SCHIP programs and begin collecting baseline data for those measures. In FY 2004, CMS and the States will refine data submission, methodological processes and reporting, and CMS will collect baseline data from the States to begin measuring progress.

Performance Goal MMA2-04

Increase the Percentage of Medicaid Two-Year Old Children Who Are Fully Immunized



Discussion: Providing children with the complete series of vaccinations in the first two years of life is a widely accepted public health goal. It is a highly effective intervention to prevent certain diseases, including measles, mumps, rubella (German measles), polio, tetanus, diphtheria, pertussis (whooping cough), and meningitis. Children are required to be immunized in order to enter school and 95 percent or more of American children are adequately vaccinated by kindergarten. However, approximately one million pre-school age children are not adequately protected against possibly fatal illnesses. With increasing numbers of children more readily exposed to infectious disease in day-care settings and elsewhere, complete immunization by age two is critical.

Healthy People 2010 continues to strive for 90 percent immunization coverage level for two-year olds as a national health promotion and disease prevention objective. Currently, 77 percent of two-year olds are fully immunized. However, studies indicate that certain subgroups have much lower coverage rates. The CMS, working in conjunction with the States and the District of Columbia, has developed a three-stage process for its Medicaid Immunization Goal. Figure 1 outlines the time frames associated with the development

MEDICAID

of individual State baselines and methodologies for reporting immunization coverage for two-year old children enrolled in Medicaid. The phase-in process of Group I, Group II, and Group III States and their subsequent reporting years are also identified. Once a State has established a baseline, it will set a target for improvement to be achieved after the third year of re-measurement. Quality improvement interventions will also be identified to help reach the target.

During the baseline development years, CMS will work closely with the group of States to assist them with developing a baseline methodology to measure immunization rates of two-year old Medicaid children. Technical assistance will be provided through the Centers for Disease Control and Prevention (CDC) and CMS as determined necessary by States and CMS.

States have a number of options to select as they collect immunization coverage information on two-year old Medicaid children. Since Medicaid is a State-run program, it is best for States to determine how to measure their own immunization rates and to determine their own performance targets. As such, comparisons between States will not be useful or meaningful.

The methodologies chosen by individual States will depend on a number of factors. For example: the service delivery systems used in that State, the existence of functional State or regional registries, and the average duration a Medicaid beneficiary remains enrolled in the program. The baseline measure will define for each State, continuous enrollment in Medicaid, the State's classification of a two-year old, and the State's classification of "fully-immunized." For Medicaid beneficiaries who are in managed care, continuous enrollment refers to enrollment in a specific managed care plan for the specified length of time. For Medicaid beneficiaries in primary care case management (PCCM) and fee-for-service (FFS), it refers to continuous enrollment in the Medicaid program for the specified length of time.

The original development timeline for the goal allotted one year for development and reporting of baseline measures for the States. After working with Group I States for a year, it became evident that more time would be needed by States to fully develop both their measurement methodologies. Reasons for the extension include variations in State reporting cycles for immunization data, data problems, and staff and resource limitations.

Coordination: The CMS has worked closely with States, the CDC, and the American Public Human Services Association (APHSA) to develop a strategy for this goal. APHSA will continue to act as a liaison between the States and CMS. The CDC will continue to partner with CMS, as we provide technical assistance to all States over the course of this goal. The Value-Based Purchasing Group, comprised of State Medicaid Directors and representatives of CMS senior management, have distributed an Immunization Resource Guide to Medicaid Directors. This guide supports the immunization goal by providing information about value-based, quality-focused immunization purchasing strategies.

Data Source(s): Due to the various data collection and reporting methodologies likely to be used by individual States, immunization coverage levels will not be directly comparable across States. However, each State will measure its own progress, using a consistent measurement methodology.

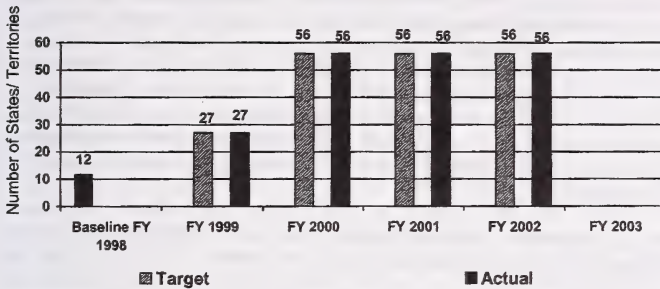
The Health Plan Employer Data Information Set (HEDIS®), the Clinical Assessment and Software Application (CASA), and immunization registries provide standardized measurement of childhood immunization. HEDIS provides a plan-based measure of the care delivered to enrollees; it is the national standard in performance measurement for managed care organizations (MCOs). The HEDIS® Childhood Immunization Measure estimates the percentage of children in an MCO who received all of the appropriate immunizations by their second birthday. CASA is a public domain tool that was developed by the CDC for measuring immunization performance at the provider or clinic level.

Verification and Validation: The means for verifying and validating immunization data will vary from State to State, depending on the State-specific data collection methodology. A key part of the technical assistance provided by CMS and the CDC will include helping States address data reliability.

 MEDICAID

Performance Goal MMA3-02

Provide to States Linked Medicare and Medicaid Data Files for Dually Eligible Beneficiaries
(Discontinued after FY 2002)



Discussion: Individuals who are dually eligible for Medicare and Medicaid are an important and growing population. In 2002, there were approximately seven million individuals dually eligible for Medicare and Medicaid at some point in the year. Although dually eligible beneficiaries represent about 17 percent of the Medicare population, they represent 30 percent of total Medicare expenditures. Similarly, while dual eligibles represent approximately 17 percent of the Medicaid population, they represent about 35 percent of total Medicaid expenditures.

Through continued innovation and reform in the Medicare and Medicaid programs, CMS hopes to foster a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries. In order to do this, State Medicaid program administrators need information on their dually eligible populations.

States, as well as providers of care, are increasingly interested in assessing how well our programs respond to the needs of dually entitled beneficiaries. The CMS's development of a tool for matching State finder files against Medicare enrollment files will be of assistance to States to improve the efficiency and effectiveness of the acute and long-term care services received by persons eligible for both Medicare and Medicaid. States will be able to use data from the Medicare linked files to perform analyses that can improve the understanding of the program interactions between Medicare and Medicaid and how the interactions affect access to care, costs, and quality of services. For example, the dual eligible Medicaid/Medicare data will strengthen the ability of CMS and States to develop efficient and effective risk-adjusted payment methods for dual eligibles.

Coordination: The Department of Health and Human Services and CMS have worked together to develop CMS systems tools that will support matching of State finder files against Medicare enrollment and Group Health data, and provide that matched data back

to States in a standard format. This effort has included collaboration with States to establish useful access to Medicare operational data.

Data Source(s): The joint Federal and State interest in dual eligibles has resulted in an examination of the data that are available to obtain knowledge about the demographic characteristics, health status, disease episodes, support services, health services utilization, and expenditures of this diverse population. The best and most current source for Medicare enrollment and Group Health data is the Medicare enrollment database (EDB). By matching current EDB data against State-submitted Medicaid finder files, CMS can provide States with accurate data identifying dual eligibles in their Medicaid populations. Based on these data, States can perform valuable analyses of their dual eligible populations. States can also then develop target populations for which they can request Medicare billing data. This combination of enrollment and Medicare billing data provides the States a powerful analytic base against which they can evaluate many aspects of dual eligibility.

Verification and Validation: All of the systems serving as sources are crucial operational systems that have built in quality assurance checks.

 MEDICAID

Performance Goal MMA4-04

**Assist States in Conducting Medicaid Payment Accuracy
Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment
Error Rates**

Baseline: Prior to FY 2001, Illinois, Texas, and Kansas have independently developed methodologies to conduct State level Medicaid payment accuracy studies; no suitable methodology to produce national level estimates has been developed.
FY 2004 Target: Pilot test the CMS PAM Model in up to twenty-five States and develop the final specifications for the model; this model is expected to produce both State specific and national level estimates. This model was developed as a result of FY 2002 experiences and initially pilot tested with twelve States during FY 2003.
FY 2003 Target: Expand the PAM Program to twelve States. Pilot test the CMS PAM Model in all twelve of these States. Assess the FY 2002 nine State experiences and review final reports; collaborate with the States, The Lewin Group, and others in CMS and OIG to develop draft final specifications for the CMS PAM Model.
FY 2002 Target: Nine pilot States will conduct payment accuracy measurement studies. The CMS and The Lewin Group (contractor) will work with the pilot States, and assess Medicare and other Medicaid payment accuracy measurement experience to define several promising methodologies for testing in FY 2003 and 2004. Contingent upon the availability of special grant funds, we will solicit participation by up to 15 States in Year 2 of the pilot (FY 2003).
Performance: Goal met. Nine States have developed payment accuracy methodologies as part of their participation in the pilot study; final reports will be reviewed as part of the FY 2003 Target.
FY 2001 Target: Establish the feasibility of conducting pilot projects within States. We will work with two States to conduct payment accuracy studies. The preliminary data gathered from these two States would be used to help refine payment accuracy methodologies and assess the feasibility of constructing a single methodology that could be used by all States.
Performance: Goal not met. Delays in receipt of funding to support State pilot studies and outside consultant assistance, and in soliciting State participation in the pilot, resulted in our not approving until late September 2001 the outside contractor and the initial group of pilot States.

Discussion: The CMS is committed to assisting interested States in developing methodologies and conducting pilot studies to measure and ultimately reduce Medicaid payment error rates. The purpose of this goal is to explore the utility and feasibility of conducting Medicaid payment accuracy studies in all States using a single methodology. No accepted methodology for Medicaid payment accuracy measurement (PAM) currently exists, and only a handful of States have done any work in this area. Those that have done so have all used different approaches, and none have addressed PAM in a managed care environment.

During FY 2000, CMS, together with the American Public Human Services Association, established a National Medicaid Payment Accuracy Workgroup to help define, guide and coordinate this Federal-State collaborative project. Information was collected on the significant Medicaid payment accuracy studies conducted to date (by Illinois, Texas and Kansas), and discussions were initiated with several States that might be interested in participating in the pilot studies.

Resource constraints have proved a major obstacle to States conducting Medicaid payment accuracy studies. In order to support States in these activities, in FY 2001 and FY 2002, CMS requested funding from the "wedge" portion of the Health Care Fraud and Abuse Control (HCFAC) account; \$2,552,000 was approved.

This program funding was used to retain a consultant to work on the project and to subsidize State participation in the first year of the demonstration project. The consulting contract was awarded in September 2001 to The Lewin Group. A letter requesting proposals was sent to all State Medicaid and Program Integrity Directors on July 3, 2001. The CMS approved funding for all nine States that applied: Louisiana, Minnesota, Mississippi, New York, North Carolina, North Dakota, Texas, Washington and Wyoming. The approved first-year budgets for the States total \$3.6 million. The pilots will be 100 percent federally funded, with the participating States being reimbursed roughly \$1.8 million of their costs through regular Medicaid funds and roughly \$1.8 million from the HCFAC grant funds. The participating States will test various approaches to Medicaid PAM and work with CMS and The Lewin Group to maximize the collective learning.

The CMS anticipates expanding the pilot study to twelve States in the second year. FY 2002 HCFAC funds totaling \$2,675,000 have been approved to subsidize this project during FY 2003. As in the first year, the HCFAC funding will be used to retain our consultant contractor and partially subsidize State participation. Our goal is to further develop, refine, and pilot test the CMS PAM Model that can be used to produce State-specific and national Medicaid payment accuracy rates. During the second year of the project, we intend to pilot test the CMS PAM Model in all twelve States. The CMS and The Lewin Group will also develop draft final specifications for the CMS PAM Model to be pilot tested in up to twenty-five States in FY 2004.

Coordination: Coordination within CMS will occur to ensure that our relevant Medicare, Medicaid and program integrity staff work together and with the Office of Inspector General. The CMS will work closely with the pilot States, as well as with States collectively through the National Association of State Medicaid Directors. During the second year, The Lewin Group will be providing technical assistance to all twelve States pilot testing the CMS PAM Model.

Data Source(s): The nine pilot States in the first year used their own Medicaid paid claims, encounter data, and related medical records, and tested differing PAM methodologies. During the second year, all twelve States will continue to use their own paid claims and medical records, however, all twelve states will be pilot testing the CMS PAM Model.

Verification and Validation: The CMS and The Lewin Group will work with the pilot States, Medicare and the Inspector General to evaluate the various PAM methodologies, including the data sources and validation techniques. During the second year, CMS and The Lewin Group will work closely with all twelve States pilot testing the CMS PAM Model to ensure that implementation is consistent across the participating States.

MEDICAID

Performance Goal MMA5-04

**Improve Health Care Quality Across Medicaid and
the State Children's Health Insurance Program (SCHIP)**

Baseline: Developmental.

FY 2004 Target:

-- **Medicaid**

(a) Refine data submission, methodological processes, and reporting; (b) Produce 2002 performance measures in standardized reporting format (testing phase); and (c) Collect 2003 data (baseline) from States.

-- **SCHIP**

(a) Refine data submission, methodological processes, and reporting; (b) Produce 2002 performance measures in standardized reporting format (testing phase); and (c) Collect 2003 data (baseline) from States.

FY 2003 Target: To begin working with States on the Performance Measurement Partnership Project (PMPP).

-- **Medicaid**

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; (b) Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; and (c) Initiate action steps for implementing recommendations.

-- **SCHIP**

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; (b) Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; and (c) Initiate action steps for implementing recommendations; and (d) Begin to implement core SCHIP performance measures.

Discussion: The use of performance measures to improve health care quality is widespread in the public and private sectors. However, its use in the Medicaid program has been primarily undertaken by State Medicaid agencies. At the national level, we are only beginning to collect and analyze information on health care quality for the majority of Medicaid beneficiaries receiving care in non-institutional settings. Since we are still far from having a complete picture of the quality of care that the Medicaid population receives on a national basis, the Medicaid program's ability to fully respond to and take advantage of the Government Performance and Results Act (GPRA) in a manner that best achieves the stated purposes of the Act is not yet realized.

The CMS took a first step in 1999 to improve health care quality for a high priority population of Medicaid beneficiaries--children--with its GPRA goal to improve childhood immunization (MMA2-04).

The following evidence supports the position that the use of performance measurement can improve service delivery to those individuals it is intended to serve:

- knowledge and experience we gained from the childhood immunization project;
- expanding use of performance measures in the health care industry;

MEDICAID

- increasing experience of States in using performance measures in Medicaid programs, and
- provisions of the Balanced Budget Act of 1997 requiring the use of performance measures for the SCHIP program

Because of the Federal-State partnership in the Medicaid and SCHIP programs, improvements in the use of performance measures would be best accomplished if jointly identified by both CMS and States.

In FY 2002, CMS began working with States to jointly explore a strategy for State and Federal use of performance measures. CMS asked States to help chart a course of action that would effectively use reliable and valid performance measures to quantify and stimulate measurable improvement in the delivery of quality health care. The Performance Measurement Partnership Project (PMPP) is Medicaid's first effort to develop performance measures based on consensus and voluntary State participation. As part of this effort, seven HEDIS® measures were proposed by a workgroup of State Medicaid and SCHIP officials as performance indicators that States would report annually on a voluntary basis.

The purpose of this goal is to utilize the information gathered from States to establish formal collaborations that will improve health care delivery and quality for Medicaid and SCHIP populations using reliable and valid performance measures.

By the end of FY 2003, CMS and States will have agreed on a strategy for the coordinated use of performance measures within and across Medicaid and SCHIP programs for quality improvement in both fee-for-service and managed care delivery systems. Our communications with States to-date indicate that they will be supportive of this position. As CMS and States proceed to implement this mutually-agreed upon strategy, we will identify multiple approaches to using performance measures to achieve improvements in health care quality.

It will take time and additional work to develop specifications for reporting the performance measures for FFS delivery systems. States will report their values (on a voluntary basis) for the seven HEDIS® measures to CMS until such time as a unified data system can be used to calculate measures on behalf of States. SCHIP performance measures will be collected through the SCHIP annual report framework each year.

Coordination: CMS will work with State Medicaid and SCHIP programs to develop a strategy for performance measurement to improve health care delivery and quality for Medicaid and SCHIP populations.

Data Source(s): Developmental. Once CMS and the States have identified the strategy for appropriate use of performance measurement, we will develop data sources to measure accomplishment of this strategy.

Verification and Validation: Developmental.

 SCHIP

State Children's Health Insurance Program
--

State Children's Health Insurance Program	FY 2001 Enacted	FY 2002 Enacted	FY 2003 Current Law	FY 2004 Current Law
Budget Authority	\$4.2 B	\$3.1 B	\$3.2 B	\$3.2 B
Redistribution Funding	\$2.0 B	\$2.8 B	\$2.2 B	TBD
Total Budget Authority	\$6.2 B	\$5.9 B	\$5.4 B	\$3.2 B

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP). This program makes an unprecedented investment toward improving the quality of life for millions of vulnerable, uninsured, low-income children. The statute authorizes and appropriates an annual amount that CMS grants to States and Territories with an approved SCHIP plan. States were given the option to expand their Medicaid program, establish a separate SCHIP program or a combination of both. Currently, all States and Territories have approved SCHIP plans. Many States are submitting plan amendments and section 1115 waivers to further expand insurance coverage under SCHIP.

Another representative goal related to this budget category but not listed in the chart below is:

- Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) (MMA5-04)

SCHIP

Performance Goal	Targets	Actual Performance	Ref.
Decrease the number of uninsured children by working with States to implement SCHIP and by enrolling children in Medicaid -- Increase the number of children enrolled in regular Medicaid or SCHIP	FY 04: + 5% over 2003 FY 03: + 5% over 2002 FY 02: + 1,000,000 over 2001 FY 01: + 1,000,000 over 2000 FY 00: + 1,000,000 over 1999 FY 99: Develop goal; set baseline and targets	FY 04: Expected late 12/04 FY 03: Expected late 12/03 FY 02: Additional 1,200,000 children enrolled in SCHIP and Medicaid (Goal met) FY 01: Additional 3,441,000 children enrolled in SCHIP and Medicaid (Goal met) FY 00: Additional 1,679,000 children enrolled in SCHIP and Medicaid (Goal met) FY 99: Baselines and targets set (Goal met); 21,980,000 FY 98: 21,180,000 FY 97: 21,000,000 in Medicaid, none in SCHIP (Baseline)	SCHIP1 See FY 03 Revised Final 3

Performance Results Discussion

Decrease Uninsured Children - The implementation of SCHIP has stimulated enormous change in the availability of health care coverage for children and in the way government-sponsored health care is delivered. The energy invested by States and Territories, communities, and the Federal Government has resulted in significant expansions in coverage, as well as new systems for enrolling children. The CMS and the States exceeded our FY 2002 goal to enroll an additional 1,000,000 children in SCHIP or Medicaid over the previous year's level. In fact, due to the overwhelming success of the program, we enrolled 1,200,000 children over FY 2001's level.

When The State Children's Health Insurance Program began in 1997, CMS implemented an enrollment goal to enroll five million children in the program by FY 2005. Because we have exceeded this goal and are now seeing States face fiscal challenges that may affect program outreach and enrollment, we are unsure about future projections and have decided to set our FYs 2003 and 2004 targets to increase enrollment by five percent over the previous year.

SCHIP

Performance Goal SCHIP1-04

Decrease the Number of Uninsured Children¹ by Working with States to Implement SCHIP and by Enrolling Children in Medicaid

Baseline: In 1997, the year SCHIP was enacted, there were 21,000,000 children enrolled in Medicaid, and none in SCHIP.
FY 2004 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 5% over the previous year.
FY 2003 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 5% over the previous year.
FY 2002 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 1,000,000 children from the previous year. Performance: Goal met. Increased the number of children enrolled in regular Medicaid or SCHIP by an estimated 1,200,000 from the previous year.
FY 2001 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 1,000,000 children from the previous year. Performance: Goal met. Increased the number of children enrolled in regular Medicaid or SCHIP by an estimated 3,441,000 from the previous year.
FY 2000 Target: Increase the number of children who are enrolled in regular Medicaid or SCHIP by 1,000,000 children from the previous year. Performance: Goal met. Increased the number of children enrolled in regular Medicaid or SCHIP by an estimated 1,679,000 from the previous year.
FY 1999 Target: Develop a goal; set baseline and targets. Performance: Goal met.

Discussion: Enacted through the Balanced Budget Act of 1997, the State Children's Health Insurance Program (SCHIP), under Title XXI of the Social Security Act, allocates nearly \$40 billion over 10 years to extend health care coverage to low-income, uninsured children. SCHIP enables States to establish separate SCHIP programs, expand existing Medicaid programs, or use a combination of both approaches. Although estimates of insurance coverage for children vary, the Bureau of Census' annual March health insurance supplement to the Current Population Survey (CPS) is the most widely cited source. The CPS data for 1999 suggested that there were approximately 10 million children under the age of 19 who lacked health insurance coverage. Approximately one-third of uninsured children are eligible for Medicaid and are not enrolled in the program.

The implementation of SCHIP has stimulated enormous change in the availability of health care coverage for children and in the way government-sponsored health care is viewed and delivered. The energy invested by States, communities, and the Federal

¹ Children = up to age 19 for SCHIP and up to age 21 for Medicaid.

SCHIP

Government in the SCHIP program has resulted in significant expansions in coverage as well as new systems for enrolling children into publicly funded coverage programs. In many States, mail-in applications for children are used in separate SCHIP-funded child health programs and in Medicaid, and paperwork requirements imposed on families applying for coverage have been reduced significantly. According to the Statistical Enrollment Data System (SEDS), approximately 5.3 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) in FY 2002, and many more were enrolled in "regular" Title XIX Medicaid through increased outreach efforts and application simplification strategies undertaken as a result of SCHIP.

When CMS conducted on-site reviews of States' Temporary Assistance for Needy Families (TANF) and Medicaid application and enrollment procedures in 1999, we found that the degree of investment States make to redesign their strategies--both to adapt to changes in law and to address longstanding barriers--profoundly affect whether or not eligible children and families receive Medicaid. Enrollment simplification, outreach, and changing the attitude toward government-sponsored health care can make a difference. Many States have simplified the application process for children, and CMS is encouraging States to make further improvements. However, many States have not made efforts to streamline and simplify practices for low-income families to the extent that they have for children; these Medicaid application procedures for families often remain tied to welfare program procedures. This has meant that the poorest children and their families often experience more barriers to coverage.

Despite many successes prompted by SCHIP, many children and families eligible for SCHIP and Medicaid have not been enrolled. Recent studies reveal that key remaining barriers include: 1) burdensome application or eligibility determination processes, 2) lack of awareness about the programs, 3) assumptions on the part of families that they are not eligible for the programs, and 4) the lingering stigma attached to government-sponsored assistance.

The best available data show 21 million children ever enrolled in Title XIX Medicaid during FY 1997 (before the inception of SCHIP).

Year	Children Served by SCHIP (Title XXI)	Children Served by Medicaid (Title XIX)	Total Number of Children Served by SCHIP & Medicaid	Yearly Increase in Number of Children Served by SCHIP & Medicaid	GPRA Target (yearly increase in number of children served)
1997	0	21,019,000 ²	21,019,000	---	
1998	980,000	20,200,000	21,180,000	161,000	

² Ku, Leighton and Brian Bruen, "The Continuing Decline in Medicaid Coverage," December 1999. Available on The Urban Institute website at http://newfederalism.urban.org/html/anf_a37.html.

SCHIP

Year	Children Served by SCHIP (Title XXI)	Children Served by Medicaid (Title XIX)	Total Number of Children Served by SCHIP & Medicaid	Yearly Increase in Number of Children Served by SCHIP & Medicaid	GPRA Target (yearly increase in number of children served)
1999	1,980,000	<i>20,000,000</i>	<i>21,980,000</i>	<i>800,000</i>	
2000	3,334,000	<i>20,325,000</i>	<i>23,659,000</i>	<i>1,679,000</i>	1,000,000
2001	4,600,000	<i>22,500,000</i>	<i>27,100,000</i>	<i>3,441,000</i>	1,000,000
2002	5,300,000	<i>23,000,000</i>	<i>28,300,000</i>	<i>1,200,000</i>	1,000,000
2003	--	--	--	--	5%
2004	--	--	--	--	5%

Note: Italicized figures are estimates based on incomplete Title XIX data submitted by the States. These estimates will be updated as edited HCFA-2082 data become available.

Coordination: To assure that both Medicaid and SCHIP fulfill their potential, CMS is working with States, various operating divisions within HHS, other Federal Government agencies, and the private sector on a broad array of outreach activities. These activities include providing technical assistance to States, providing new resources to States to help them improve their programs, working with other Federal agencies; and promoting the exchange of information among States, community-based organizations, advocacy groups, Government grantees, and private sector groups -- just to mention a few.

For example, CMS has contracted with Maximus to develop model applications for the Medicaid and SCHIP programs. The applications will be designed to target the appropriate reading levels of potential enrollees and will be available in both English and Spanish. Additionally, Maximus will develop model notices that are most frequently sent to Medicaid and SCHIP enrollees for States to adopt into their programs. These efforts serve not only to improve the readability of applications and notices but also to provide a better understanding of how to enroll and access services under Medicaid and SCHIP. Related efforts include convening regional conferences and the National Summit on School-Based Outreach for SCHIPs; identifying successful school-based outreach and enrollment strategies for SCHIP and Medicaid; and collaborating with the American Public Human Services Association to exchange best practices among States.

Data Source(s): States are required to submit quarterly and annual State Children's Health Insurance Program statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS) (formerly known as Statistical Information Management System). Using these forms, States annually report unduplicated counts of the number of children under age 19 who are enrolled in separate SCHIP programs, Medicaid expansion SCHIP programs, and regular Medicaid programs. The SCHIP enrollment counts presented in this update are the sum of the unduplicated number of children ever enrolled in separate SCHIP programs during the year and the unduplicated

number of children ever enrolled in Medicaid expansion SCHIP programs during the year.

The estimate of 21,000,000 for Medicaid enrollment for FY 1997 is based on HCFA-2082 data edited by The Urban Institute and published in December 1999. Although we previously reported a 1997 baseline of 22,700,000 children enrolled in Medicaid, this was based on unedited HCFA-2082 data and incomplete data reported by the States through SEDS. The CMS and the States consider the 21,000,000 Medicaid enrollment figure to be a final estimate for 1997. This figure is also cited in the first annual report of the CMS-funded evaluation of SCHIP by Mathematica Policy Research (posted on the web at <http://cms.hhs.gov/schip/mpr12301.asp>).

The 1998-2001 Medicaid enrollment counts presented are estimates based on interim data submitted by the States through SEDS and are therefore subject to change when edited HCFA-2082 data become available. In general, edited data for a fiscal year are available about two years after the end of the year.

States may eventually report all of their SCHIP and Medicaid data through the Medicaid Statistical Information System (MSIS). Reporting Medicaid data through MSIS is now required for all States; and we are working with States to help them use MSIS to streamline their Medicaid and SCHIP reporting and improve CMS's ability to analyze data across programs. However, there are significant time lags in collecting and editing these data through MSIS. Therefore, we will continue to rely on the States' quarterly and annual statistical report submissions through SEDS, with updates from edited HCFA-2082 data, as such data become available.

Verification and Validation: The program enrollment data that States submit through SEDS are reviewed by CMS personnel every quarter. These data also are subject to audit and are being reviewed and analyzed as part of a National Evaluation contract awarded to Mathematica Policy Research.

The CMS will measure, to the extent possible, the unduplicated count of the number of children who are enrolled in any of the following programs: regular Medicaid; expansions of Medicaid through SCHIP; and separate SCHIP programs as reported by the States. While we consider an unduplicated count to be an appropriate measure for this goal and we can measure the unduplicated count within each program, some children may be enrolled in Medicaid at one point in the year and in SCHIP at another point, making it difficult to establish an accurate unduplicated count across all programs. Similarly, the SCHIP counts include some double counting of children in States that have combination programs. To the extent our data allow, we will closely monitor this issue.

CLIA

Clinical Laboratory Improvement Amendments (CLIA)

Clinical Laboratory Improvement Amendments	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Collections/ Budget Authority	\$40.8 M	\$43.7 M	\$43.0 M	\$43.0 M

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) strengthen quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens for health purposes. There are approximately 177,300 CLIA certified laboratories. Approximately 78 percent (138,565) of these laboratories perform test methodologies that are so simple and accurate that the likelihood of erroneous results is negligible and, therefore, are not subject to proficiency testing (PT). Under CLIA, CMS will continue its partnership with the States to certify and inspect approximately 21,800 laboratories during the FY 2004 - 2005 survey cycle. This is the number of non-accredited laboratories to be surveyed every two years.

Performance Goal	Targets	Actual Performance	Ref.
Sustain improved laboratory testing accuracy			CLIA1
— Percentage of laboratories enrolled in proficiency testing (PT) with no failures	CY 04: Goal Discontinued CY 03: 90% CY 02: 90% CY 01: 90% CY 00: 90% CY 99: 90%	CY 04: N/A CY 03: Expect data 3/04 CY 02: Expect data 3/03 CY 01: 92.5% (Goal met) NEW DATA CY 00: 91.9% (Goal met) CY 99: 91.3% (Goal met) CY 98: 88.1% CY 97: 88.6% CY 96: 87.4% CY 95: 69.4% (Baseline)	
-- Laboratories properly enrolled and participating in PT	CY 04: Goal Discontinued CY 03: 95% CY 02: 95% CY 01: 95% CY 00: 95% CY 99: 95%	CY 04: N/A CY 03: Expect data 3/04 CY 02: Expect data 3/03 CY 01: 96.4% (Goal met) NEW DATA CY 00: 96.4% (Goal met) CY 99: 95.4% (Goal met) CY 98: 94.8% CY 97: 94.4% CY 96: 93.2% CY 95: 89.6% (Baseline)	

CLIA

Performance Goal	Targets	Actual Performance	Ref.
Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver -- Increase the percentage of laboratories adhering to manufacturer's instructions	FY 04: TBD FY 03: New in FY 2004	FY 04: Expect data Spring 2005	CLIA2

Performance Results Discussion

Proficiency Testing -- Success in our PT program increases patient and physician confidence by producing a snapshot of a laboratory's ability to perform tests accurately. It also reduces the need for repetitive testing, which will reduce overall costs of medical care related to diagnostic testing. We exceeded our 2001 targets to sustain improved testing accuracy with 92.5 percent of laboratories having no failures and 96.4 percent of laboratories properly enrolled in PT. Interim data for our 2002 targets show that 92.7 percent of laboratories enrolled in PT with no failures and 97.1 percent of laboratories properly enrolled and participating in PT. Final data for our 2002 targets are expected in March 2003, and based on interim data we anticipate success.

The CMS feels that we have reached peak performance with the percentage of laboratories enrolled in PT with no failures and with the percentage of laboratories properly enrolled and participating in PT. We recognize that it is important to maintain these levels of laboratory testing accuracy and to continue to monitor performance in these target areas. However, we see a new opportunity to positively impact laboratory testing, by focusing on waived laboratory procedures (See CLIA2-04).

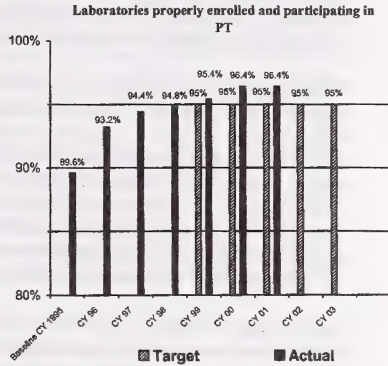
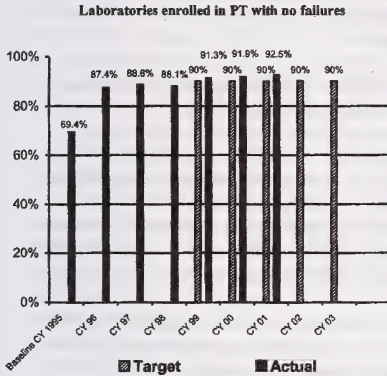
We will continue to report on our current PT goal through FY 2003, while gathering baseline data for our new goal. In FY 2004 we will report our new baseline and begin measuring improvement in the percentage of laboratories having/following manufacturer's instructions.

Waived Laboratory Testing -- Beginning in FY 2004, CMS is introducing a new goal to measure the percentage of laboratories performing waived tests (not subject to proficiency testing) that have/follow manufacturer's instructions. Currently, 78 percent of CLIA certified laboratories perform test methodologies that are so simple that the likelihood of erroneous results is negligible and, therefore, are not subject to PT.

In FY 2002, an expanded pilot study of waived and provider-performed microscopy procedures laboratories in eight States demonstrated that 50 percent of laboratories performing waived tests did not have manufacturer's instructions or did not follow manufacturer's instructions (if they did have them). Based on data collected during revisits to waived laboratories that received education during and after the initial survey, awareness of and adherence to manufacturer's instructions improved considerably.

In FY 2003, CMS is conducting surveys on a nationwide sample to assess the number of laboratories performing waived tests that do not have manufacturer's instructions or do not follow manufacturer's instructions. A national baseline will be determined from this data, and in FY 2004, we will begin measuring improvement.

Performance Goal CLIA1-03

Sustain Improved Laboratory Testing Accuracy
(Discontinued after FY 2003)

Discussion: Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. CLIA specifies quality standards for proficiency testing (PT), which provides CMS with a means of measuring laboratory performance. A laboratory's performance of PT provides CMS surveyors, CLIA surveyors, inspectors of approved accreditation organizations, and surveyors of approved State licensure programs with an excellent overview of the laboratory's current ability to produce accurate patient test results. Because of the continuous monitoring of PT by these individuals and the value of PT in general, we decided to use PT enrollment and successful PT performance as our target areas for improvement for this goal.

PT involves sending sample specimens with known properties to each laboratory three times per year, the results of which are not known to the laboratory. Laboratories' PT results are then evaluated for accuracy by CMS-approved private and State operated PT programs, following CLIA PT requirements. The PT testing is "blind," in that the laboratory staff members are not given any information about what they are expected to find. The CLIA regulation requires that the PT samples be tested in the same manner and by the same individuals as those performing patient testing.

Laboratory personnel, tests offered, and even laboratory size, location and environment are never constant. Because each can have a significant impact on test performance, we

decided to set our initial goals at the highest realistic levels possible, taking into consideration that many laboratories had never been regulated before CLIA. Setting high initial targets (what we believed to be a maximum expectation for 38,000 laboratories, with no assurance they could be met) gave us true goals to strive for in our ever-changing health care environment, and we believed anything less stringent would not have been acceptable, considering the clinical impact of laboratory results on the beneficiaries of Medicare and Medicaid, as well as all other patients.

PT increases patient and physician confidence in a particular laboratory by producing a snapshot of the laboratory's ability to perform tests accurately according to objective standards. This enhanced confidence in laboratory test accuracy reduces the need or inclination for repetitive laboratory testing and thereby reduces the overall costs of medical care related to diagnostic testing. Typically, a laboratory that performs well on PT also provides accurate testing results for clinicians, which aids in rapid and appropriate patient diagnoses and therefore contributes to effective treatment. There is a well-documented educational value for the laboratory from PT because of the opportunity and incentive for the laboratory to learn from its PT performance.

There are approximately 177,300 CLIA certified laboratories. Approximately 78 percent of these laboratories perform test methodologies that are so simple and accurate that the likelihood of erroneous results is negligible and, therefore, are not subject to PT. (There are approximately two percent of laboratories that are CLIA-exempt; that is, they are located within States with CMS approved State licensure programs.) The remaining 22 percent of the laboratories must perform PT on the required tests or analytes and are overseen directly by CMS, the State survey agencies, or private accrediting organizations. There are currently 86 tests or analytes (i.e., cholesterol, glucose, white blood cell count, etc.) for which laboratories must perform PT under CLIA. This list of 86 analytes is largely made up of diagnostic tests, which are commonly performed and whose results are important to health care treatment decisions. Each laboratory performs PT on the required analytes that are a part of its specific test menu.

The CMS feels that we have reached peak performance with the percentage of laboratories enrolled in PT with no failures and with the percentage of laboratories properly enrolled and participating in PT. We feel that it is important to maintain these levels of laboratory testing accuracy and to continue to monitor performance in these target areas. However, we see a new opportunity to positively impact laboratory testing, by focusing on waived laboratory procedures (See CLIA2-04).

We will continue to report on our current PT goal through FY 2003, while gathering baseline data for our new goal. In FY 2004 we will report our new baseline and begin measuring improvement in the percentage of laboratories having/following manufacturers instructions.

Coordination: The CMS works closely with State surveyors, CMS-approved accreditation organizations, PT programs, CMS-approved State laboratory licensure

programs (CLIA-exempt laboratories) and professional advocacy groups in carrying out its CLIA activities.

Data Source(s): The primary data source is the Online Survey Certification and Reporting System (OSCAR). The PT enrollment rate is calculated using: (1) the number of laboratories in the OSCAR database that were subject to on-site survey and PT testing for at least one analyte, and (2) the number of laboratories cited as deficient for failing to be appropriately enrolled in PT. The rate at which enrolled labs perform successfully on PT is calculated using totals from the OSCAR database for: (1) the total number of tests performed for the year; and (2) the total number of failed scores received for the year.

Verification and Validation: Surveyors verify this data through ongoing monitoring of PT information, communicating with the laboratories and PT programs and by conducting biennial on-site surveys. The PT programs that provide the samples undergo an annual and ongoing review process coordinated by CMS with assistance from the Centers for Disease Control and Prevention. For example, the PT data system and PT programs are monitored to ensure that PT data transmitted to CMS is accurate, complete and timely.

Performance Goal CLIA2-04

Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver

Baseline: Developmental. In FY 2003, baseline data will be collected on a national scale for the number of laboratories holding a certificate of waiver that do not have manufacturer's instructions or do not follow manufacturer's instructions.

FY 2004 Target: To be determined. We will determine our FY 2004 target once we have reviewed baseline data.

Discussion: Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988, establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. Certificates are issued to laboratories based on the complexity of testing that they perform. Laboratories are issued a certificate of waiver if they perform only waived tests. A waived test is defined as a simple laboratory test that has been determined by the Secretary of the Department of Health and Human Services to have an insignificant risk of erroneous results. Laboratories performing waived tests are required to follow manufacturer's instructions for performing the test, but they are not routinely surveyed.

In two independent studies, State surveyors in Colorado and Ohio found that about half of waived and provider-performed microscopy laboratories were out of compliance. Specifically, waived laboratories were not following manufacturer's instructions, did not have manufacturer's instructions onsite, or were conducting tests they were not authorized to perform. Those results were cited in a March 2001 report from the Office of the Inspector General (OIG) titled "Enrollment and Certification Processes in the Clinical Laboratory Improvement Amendments Program". These findings led to CMS initiating a pilot study in eight other states. The findings of the pilot mirror those of previous studies conducted by the states of Colorado, Ohio, and New York. The pilots demonstrated that 50 percent of laboratories performing waived tests did not have manufacturer's instructions or did not follow manufacturer's instructions (if they had them). If this percentage is nationally representative, as many as 60,000 laboratories may not be following manufacturers' testing instructions and may be performing tests incorrectly, with the potential result of patient harm.

Based on data collected in the above studies, during revisits to waived laboratories that received education during and after the initial survey, awareness of and adherence to manufacturer's instructions improved considerably.

In FY 2003, CMS is conducting surveys on a nationwide sample to assess the number of laboratories performing waived tests that do not have manufacturer's instructions or do not follow manufacturer's instructions. A national baseline will be determined from this data, and in FY 2004, we will begin measuring improvement.

Coordination: The CMS will work closely with State surveyors, the CDC, and CMS-approved accreditation organizations to further evaluate waived laboratories and to develop and implement strategies to improve the compliance of laboratories performing waived testing with the CLIA requirement of following manufacturer's instructions.

Data Source(s): The universe of laboratories to be surveyed is selected from the Online Survey Certification and Reporting System (OSCAR). The surveyors enter information collected during the surveys directly into the State Surveyors Information System (SSIS). The data in the SSIS is used to generate reports of findings for the analysis of laboratory compliance, trends and improvement. The SSIS will be the primary source for data in setting a baseline and reporting improvement. The data is collected during the survey via a standard questionnaire. The surveyor uses the answers on that questionnaire to input data into the SSIS.

Verification and Validation: Surveyors collect information on the questionnaire while on site and in contact with the laboratory. Surveyors enter the findings they have recorded into the SSIS so that national data can be gathered and analyzed. The SSIS system contains edits that prevent surveyors from entering data that is inappropriate or is inconsistent with other information on the questionnaire. A follow-up is done in 10 percent of the laboratories to validate the initial findings and improvements made by the laboratory as a result of the survey.

 MEDICARE INTEGRITY PROGRAM

Medicare Integrity Program

Medicare Integrity Program	FY 2001 Actual	FY 2002 Actual	FY 2003 Current Estimate	FY 2004 Estimate
Total Budget Authority	\$680.0 M	\$700.0 M	\$720.0 M	\$720.0 M

The CMS's program integrity efforts ensure the Medicare program pays the right amount to a legitimate provider for covered, reasonable and necessary services that are provided to an eligible beneficiary. The CMS's program integrity activities are primarily funded through the Medicare Integrity Program (MIP), established by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The MIP includes medical review and benefit integrity activities, provider education and training, Medicare Secondary Payer, and provider audits. The CMS's overall program integrity efforts are supplemented by funding from CMS's program management account and other funds made available from the Health Care Fraud and Abuse Control Account (HCFAC).

Another representative goal that are related to this budget category but is not listed in the chart includes:

- Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates (MMA4-04)

Performance Goals	Targets	Actual Performance	Ref.
Reduce the percentage of improper payments made under the Medicare fee-for-service program	FY 04: 4.8% FY 03: 5% FY 02: 5% FY 01: 6% FY 00: 7% FY 99: 9%	FY 04: FY 03: FY 02: 6.3% (Goal not met) FY 01: 6.3% (Goal not met) (NEW DATA) FY 00: 6.8% (Goal met) FY 99: 7.97% (Goal met) FY 98: 7.1% FY 97: 11% FY 96: 14% (Baseline)	MIP1 3,8 
Develop and implement methods for measuring program integrity outcomes:			MIP2
-- Implement the Provider Compliance Rate prepay medical review	FY 03: Subsumed in MIP1 FY 02: Goal not continued. FY 01: Implement program	FY 03: FY 02: N/A FY 01: Implementation complete (Goal met)	
-- Implement the refined Comprehensive Error Rate Testing (CERT) program to produce subnational error rates	FY 03: Subsumed in MIP1 FY 02: Goal not continued. FY 01: Implement program	FY 03: FY 02: N/A FY 01: Implementation complete (Goal met)	
-- Develop a fraud rate among providers in a contractor's service area	FY 03: Subsumed in MIP1 FY 02: Implement program FY 01: Develop requirements	FY 03: FY 02: Progress dependent on HCFAC funding (Goal not met) FY 01: Progress dependent on HCFAC funding (Goal not met)	

MEDICARE INTEGRITY PROGRAM

Performance Goals	Targets	Actual Performance	Ref.
Improve the effectiveness of program integrity activities through successful implementation of the Comprehensive Plan for Program Integrity: — Successfully implement the Comprehensive Plan — Measure effectiveness by achieving a significant portion of the performance measures for each of the ten Comprehensive Plan activities	FY 02: Goal not continued FY 01: 100% FY 02: Goal not continued FY 01: Meet 90% of measures for each of the activities: 1a. Develop carrier/FI performance standards 1b. Implement PCR, CERT; and develop fraud rate 2. Implement program safeguard contractor (PSC) models 3a. Non-physician practitioner error rate 3b. Therapy services error rate 4. Improve the provider enrollment process 5. Assure Millennium contingency planning 6. Reduce the Inpatient hospital error rate 7. Data exchange to monitor care in congregate care settings 8. Implement managed care PSC and managed care payment validation 9. Community mental health centers error rate 10. Improve quality of care in nursing homes	FY 02: N/A FY 01: (Goal met) FY 00: N/A FY 99: Plan initiated (Baseline) FY 02: N/A FY 01: See status below 1a. Guidelines in use (Goal met) 1b. See goal MIP2 2. PSC operational models implemented (Goal met) 3a. Pending funds availability 3b. Available 02/2003 4. (Goal not met) 5. (Goal met) 6. 2.79 percent. (Goal not met.) 7. CMS contract with NHIC. Data available early FY 2003. 8. (Goal met) 9. Ten point plan implemented. Pending funds availability. 10. See goals QSC1 and QSC2 (Baseline) All new activities	MIP3

MEDICARE INTEGRITY PROGRAM

Performance Goals	Targets	Actual Performance	Ref.
Improve the Process of Credit Balance Recoveries	FY 04: Goal not continued FY 03: Fully implement revised processes and controls in contractor credit balance activities FY 02: Develop improved processes and controls to be utilized by contractors to ensure consistency and timely recoveries FY 01: Gather information on 1) provider credit balance identification, submission and resolution processes; and 2) contractor monitoring and resolution of credit balances	FY 04: Goal not continued FY 03: FY 02: Developed processes (Goal met) FY 01: See Final Review Summary Report and Final Management Overview Report (Goal met) FY 00: Incomplete information regarding credit balance reporting process (Baseline) FY 01: N/A FY 00: 29.1% (Goal met) FY 99: 20% FY 98: \$364 million (Baseline)	MIP5 See FY 03 Revised Final
Increase Medicare Secondary Payer liability and no-fault dollar recoveries ** Shaded area indicates version of the goal before the change in focus	FY 01: Goal carried over with new focus (see above) FY 00: 5% increase over baseline	FY 00: 29.1% (Goal met) FY 99: 20% FY 98: \$364 million (Baseline)	
Assess program integrity customer service	FY 04: Conduct survey and develop a corrective action plan (CAP) FY 03: Conduct survey and develop a CAP FY 02: Conduct and analyze surveys. Develop baseline and targets.	FY 04: FY 03: FY 02: Surveys are complete and a CAP has been developed (Goal met)	MIP6
Improve the provider enrollment process	FY 04: Continue to implement PECOS and revalidate 25% of Part A/Part B providers/suppliers FY 03: Implement PECOS, revalidate 20% of Part A providers FY 02: Develop PECOS, revise CMS-855, publish regulation	FY 04: FY 03: FY 02: PECOS implemented 7/29/02 (Goal met) Regulation and revised form are in clearance (Goal not met)	MIP7
Improve effectiveness of Medicare Secondary Payer (MSP) provisions by increasing number of voluntary data match agreements (VDMA) with insurers or employers	FY 04: 2 additional VDMA's	FY 04: FY 03: FY 02: 5 VDMA's (Baseline)	MIP8 8

MEDICARE INTEGRITY PROGRAM

Performance Goals	Targets	Actual Performance	Ref.
Reduce the Contractor Error Rate	FY 04: Develop baseline.	FY 04: FY 03: New in FY 04	MIP9 3,8 
Improve the Provider Compliance Rate	FY 04: Develop baseline.	FY 04: FY 03: New in FY 04	MIP10 3,8 
Decrease improper payment rate for home health services	FY 01: Goal not continued FY 00: 10% FY 99: 35%	FY 01: N/A FY 00: 29.5% (NEW DATA) (Goal not met) FY 99: 19% (Goal met) 1995-1996: 40% (Baseline)	27-00

Performance Results Discussion

Medicare Error Rate - We have achieved extremely positive results in our effort to reduce improper payments. We have virtually cut the Medicare fee-for-service error rate in half over the past few years. Although we did not meet our target of a 5 percent error rate in FY 2002, we continue to claim success in maintaining the error rate at 6.3 percent. We believe there is still important work to be done and expect to achieve our goal of further reducing the error rate.

With implementation of the Comprehensive Plan for Program Integrity in FY 2001, CMS has focused its efforts on the Comprehensive Error Rate Testing (CERT) program. The purpose of CERT is to stratify the Medicare payment error rate to strengthen our ability to target problem areas.

The CERT program was fully implemented in 2002, therefore, CMS will produce a fee-for-service error rate for Durable Medical Equipment Regional Carriers (DMERCs) for FY 2002; for all Part B carriers for FY 2002; and for Part A contractors for FY 2003. To provide further quality assurance over the error rate estimate, CMS will produce the FY 2003 error rates with oversight provided by the OIG. For FY 2004 and beyond, CMS will assume the substantive testing portion of the CFO audit.

The Provider Compliance Rate (PCR) has also been implemented and will be produced as a product of CERT medical record reviews. In fact, in keeping with our commitment to OMB during the Program Assessment Rating Tool (PART) process, CMS has developed two new FY 2004 goals measuring the provider compliance rate and the contractor error rate.

 MEDICARE INTEGRITY PROGRAM

We did not meet our FY 2002 target to develop a model fraud rate program under CERT because we did not receive the HCFAC funding to carry out this project. We may take another look at developing a fraud rate if funding is received in future fiscal years.

The Comprehensive Plan for Program Integrity – Through implementation of the Comprehensive Plan for Program Integrity, CMS has evaluated various initiatives in order to target high risk areas and better focus our resources to address problem areas. While we assessed our performance throughout the implementation process, it was also critical to monitor the overall effectiveness of each initiative in the plan throughout FY 2001. We continue to monitor many of these programs as we collect final data.

Program Integrity Customer Service – The goal to assess customer service behaviors in handling fraud and abuse cases would ultimately result in contractors developing a plan to assess customer service behaviors in the program integrity area. We have conducted surveys of beneficiaries and have analyzed the results. The CMS has formed a PI Customer Service Action Planning Team which has developed a nine point plan to improve program integrity customer service. Part of the plan includes training for contractors which was conducted during the summer of 2002.

Improve the Provider Enrollment Process - The goal to improve the provider enrollment process is an effort to continue the spirit of the Comprehensive Plan of paying claims properly to legitimate providers and suppliers. The CMS intends to have a streamlined and more uniform process for revalidating applications from providers of Medicare. To that end, CMS made the Provider Enrollment Chain Ownership System (PECOS) available to fiscal intermediaries on July 29, 2002. The fiscal intermediaries will begin to populate the system with data from new provider applications. We have not yet published the regulation pertaining to establishing and maintaining billing privileges, however, we expect to publish the regulation in early 2003. The revised CMS-855 form is pending the release of the regulation.

Medicare Secondary Payer/Credit Balance Recoveries - Medicare Secondary Payer (MSP) dollar recovery activities ensure that the appropriate primary payer makes payments for health care services for beneficiaries. The MSP activity attempts to collect timely and accurate information on the proper order of payers and to make sure that Medicare pays only for those claims where it has primary responsibility. In FY 2002, instead of focusing on no-fault dollar recoveries, we concentrated on the mandatory Medicare credit balance reporting requirements for providers. The intent of these requirements is to ensure that Medicare properly recovers improper or excess program payments resulting from patient billing or claims processing errors. Approximately 90 percent of credit balances are mainly attributable to provider billing practices. The CMS met its FY 2002 target by developing improved processes for contractors to ensure consistency and timely recoveries of credit balances. These improved processes are currently going through clearance prior to full implementation in FY 2003. We have also changed the name of the goal to "Improve the Process of Credit Balance Recoveries" to more accurately reflect the activity.

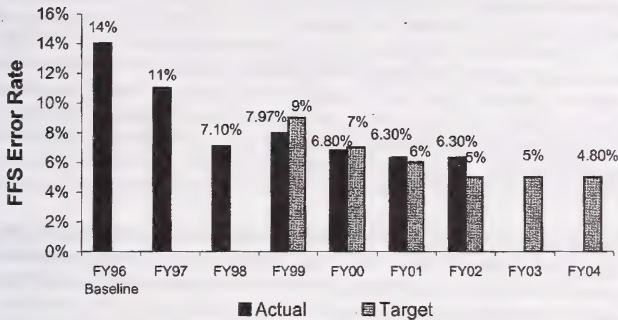
MEDICARE INTEGRITY PROGRAM

MSP Voluntary Data Match Agreements - We have introduced a new goal to further improve the effectiveness of the administration of the Medicare Secondary Payer provisions by increasing the number of Voluntary Data Match Agreements (VDMA) with insurers or employers. As we increase the number of VDMAs with large employers or insurers, we should be able to significantly decrease erroneous payments made by Medicare as the primary insurer when it should have been secondary.

Home Health Error Rate - Our efforts to reduce improper home health service payments paid off based on the repeat sampling of home health claims in California, Illinois, New York and Texas as part of an Office of Inspector General Operation Restore Trust study. This figure decreased from 40 percent in 1996 to 19 percent in 1999. In FY 2001, CMS replicated the OIG evaluation of home health claims using a sample of paid home health claims from January 1, 1999 to September 30, 1999 in the same four States, to determine if CMS's activities further reduced the rate of improper payment. Results indicate that the error rate was not reduced further; that in fact the error rate increased by approximately 10 percent resulting in a home health claims payment error rate of 29.5 percent. We believe that the increased error rate may be due to changes in provider behavior in anticipation of the implementation of the home health prospective payment system in October 2000.

This goal was discontinued in order for CMS to focus on other equally compelling fraud and abuse areas. However, in FY 2001 and following years, CMS will also continue to focus on reducing improper home health payments using a Program Safeguard Contract (PSC) Task Order to assess and recommend measures to improve the accuracy of the Outcome and Assessment Information Set (OASIS), the standardized assessment that is used to determine Medicare payment.

 MEDICARE INTEGRITY PROGRAM

Performance Goal MIP1-04**Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program**

Discussion: The purpose of this goal is to continue to reduce the percentage of improper payments made under the fee-for-service program. One of CMS's key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

The complexity of Medicare payment systems and policies, and the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. The CMS has implemented a Corrective Action Plan (CAP) designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate. Examples of the positive effects of our corrective actions on reducing improper payments are illustrated in both the 1998 and 1999 Office of Inspector General (OIG) reports.

The CMS exceeded its GPRA targets for 1999 and 2000. In general, the substantial reduction in the error rate demonstrates that the Medicare contractor claims processing system is working well. Furthermore, during previous audits, a significant portion of improper payments reported were attributable to documentation errors. However, in FY 1998, documentation errors accounted for only \$2.1 billion, a substantial decline from the \$8.7 billion reported in FY 1996. The OIG attributed much of the substantial improvement in this category to the CMS CAP. The CMS agreed to continue these corrective actions in response to both the FY 1998 and 1999 audits.

MEDICARE INTEGRITY PROGRAM

In FY 2002, CMS did not reach the target of 5 percent, however we continued our success by maintaining the error rate at 6.3 percent. We will further reduce the error rate by continuing to focus our corrective actions on areas of vulnerability identified by the OIG. We believe that by aggressively addressing specific high risk areas we will continue to be successful in reducing the fee-for-service error rate.

The Comprehensive Error Rate Testing (CERT) program will be fully implemented in FY 2003; as such, the CERT program will produce a Medicare fee-for-service error rate for FY 2003. To provide further quality assurance over the error rate estimate, CMS originally intended to run the CERT program in parallel with the CFO Audit for at least one year; therefore, during FY 2003 both programs were to be used to produce national fee-for-service error rates. However, recent meetings with the Office of Inspector General (OIG) prompted an agreement that CMS will produce the FY 2003 error rate with oversight by the OIG. For FY 2004 and beyond, CMS will be assuming the substantive testing portion of the CFO audit.

In addition to the national error rate, CERT outcomes include contractor-specific error rates, as well as three additional rates used to help measure provider compliance with Medicare payment and billing requirements, and the accuracy of the contractor's claims payments and processing activities. These rates known respectively as the provider compliance rate, claims payment and claims processing rates, allow CMS to quickly identify emerging trends in managing Medicare contractor performance.

Coordination: We will continue to work with our partners in conducting our everyday business of ensuring Medicare claims are paid properly. We will build on the successes of Operation Restore Trust by continuing to work with the OIG, Department of Justice, and State survey agencies.

Data Source(s): The payment error rate has been computed by the OIG in fiscal years 1996 through 1999 as part of their Chief Financial Officer's Act audit. The CMS and OIG entered into an agreement stipulating that the OIG would act as CMS's agent to measure the Medicare fee-for-service error rate in FYs 2000 and 2001. The CMS will assume responsibility for measuring the Medicare fee-for-service error rate beginning in FY 2003 with oversight by the OIG.

Verification and Validation: The CMS will replicate OIG's methods as much as possible for FY 2002 to ensure consistent and equal comparisons across fiscal years. The CERT program was awarded to the Program Safeguard Contractor DynCorp in FY 2000. The CERT program is monitored for compliance by CMS through monthly reports from the contractor and a PSC evaluation team.

 MEDICARE INTEGRITY PROGRAM

Performance Goal MIP2-03
**Develop and Implement Methods for Measuring
Program Integrity Outcomes
(Discontinued after FY 2003)**

Baseline: The three proposed methods are new and currently in development and testing phases. Therefore, baseline data do not exist.

FY 2003 Target: Methods to be subsumed in MIP1-04.

FY 2002 Target: To implement a model fraud rate program.

Performance: Goal not met.

FY 2001 Target: To implement the Provider Compliance Rate (PCR); the Comprehensive Error Rate Testing (CERT) program; and develop requirements for a model fraud rate program.

Performance: Goal met (model fraud rate development dependent on HCFAC funding).

Discussion: The CMS is developing better methods to measure fraud, waste, and abuse in the Medicare program. This performance goal measures our progress in developing and implementing these methods.

The **Provider Compliance Rate (PCR)** is a method of determining a "compliance rate" among providers based upon a random sample of submitted claims. Essentially, the sampled claims are subjected to detailed medical review and a compliance rate is calculated based upon the dollar value ratio of valid claims to total claims. As such, the PCR provides a very useful measure of the appropriateness of claims submitted prior to payment. The PCR has been pilot tested over a two-year period at three contractor sites and is ready for full implementation. PCR was implemented during FY 2001 as part of the CERT program at all Medicare contractors. PCR is expected to both further enhance medical review effectiveness and promote provider compliance.

The Office of Inspector General (OIG) currently administers the CFO Audit, which provides CMS with a national fee-for-service claims payment error rate. However, the CFO audit does not provide a usable measure of improper payments at subnational levels. The CMS awarded a contract to implement the **Comprehensive Error Rate Testing (CERT)** program. CERT will produce contractor, provider and benefit specific error rates. These rates can also be aggregated to produce national level estimates similar to the CFO audit but with greater precision. The CERT program will provide substantially greater detail and analysis of vulnerabilities in the current system which will help focus corrective actions. The CERT program will be implemented in three phases. Phase 1 began in August 2000 at the four Durable Medical Equipment Regional Carriers (DMERCs). Phase 2 began at the carriers in April 2001. Phase 3 was implemented at the intermediaries in January 2002.

The CERT program will be fully implemented in FY 2003; as such, the CERT program will produce a Medicare fee-for-service error rate for FY 2003. To provide further quality assurance over the error rate estimate, CMS will produce the FY 2003 error rate with

MEDICARE INTEGRITY PROGRAM

oversight by the OIG. For FY 2004 and beyond, CMS will be assuming the substantive testing portion of the CFO audit.

The CMS tasked a Medicare contractor to develop and pilot test a method for estimating a **fraud rate** among providers in a contractor's service area. The pilot program includes drawing a random sample of claims using the CERT platform, contacting beneficiaries, and conducting interviews. The beneficiary interviews are considered critical in determining whether the provider actually delivered the stated services on the claim. However, due to the complexity of measuring fraud, numerous other indicators are required in order to produce a reliable estimate. We did not meet our FY 2002 target to develop a model fraud rate program under CERT because we did not receive the funding to carry out this project. We may take another look at developing a fraud rate if funding is received in future fiscal years.

Coordination: We will continue to work with OIG, our PSC contractors, and our Medicare contractors to develop the projects identified in this goal.

Data Source(s): Monthly reports are received from the contractor to verify that they have complied with the phases proposed in the CERT implementation timetable for the Medicare contractors. The first CERT error rate and PCR reports for the four DMERCs were published in January 2002. These same reports were published for the carriers on the VMS system in April 2002 and in August 2002 for the carriers on the EDS MCS system. The first national error and PCR rates will be published for FY 2003.

Verification and Validation: The CMS verifies contractor performance and data through its Contractor Performance Evaluation program.

MEDICARE INTEGRITY PROGRAM

Performance Goal MIP3-01

Improve the Effectiveness of Program Integrity Activities through the Successful Implementation of the Comprehensive Plan for Program Integrity
(Discontinued after FY 2001)

This goal was designed to monitor the implementation and measure the effectiveness of CMS's Comprehensive Plan for Program Integrity. The Comprehensive Plan outlined CMS's overall program integrity strategy, as well as ten specific 6 to 18 month initiatives that were to improve the effectiveness of our program integrity efforts. Five of these initiatives addressed program management issues and the other five initiatives addressed specific benefit areas that we suspected were high program vulnerabilities.

PI Comprehensive Plan Performance Sub-goal	Target	Actual Performance
1(a). Increase the effectiveness of medical review and benefit integrity activities: Improve quality of medical review and benefit integrity outcomes	Develop and implement Medicare carrier and FI program integrity performance standards that measure quality and desired outcomes.	Goal met. Guidelines were tested in 1999, refined in 2000 and further streamlined for use in FY 2001
1(b). Increase the effectiveness of medical review and benefit integrity activities: Develop new methods to reduce the percentage of improper payments made under the Medicare fee-for-service program.	Implement the Provider Compliance Rate (PCR); implement the refined CFO audit methodology to produce a subnational error rate; implement a fraud rate program.	See goal MIP2-03.
2. Implement the Medicare Integrity Program	Implement four program safeguard contractor (PSC) operational models: functional, data analysis, benefit and full PSC.	Goal met. We have implemented the three PSC operational models and have awarded the contract for the fourth PSC model.
3(a). Implement Program Safeguards for BBA provisions: Establish (1) a national database of State statutes concerning non-physician practitioner licensure requirements, and (2) a process to measure the non-physician practitioner error rate.	Implement a national database of State licensure requirements for non-physician practitioners and to pay 90 percent of non-physician practitioner claims correctly.	The CMS has a database of State licensure requirements for non-physician practitioners and is in the process of making this information available to interested parties. Implementation of a non-physician practitioner error rate is dependent on funds availability.
3(b). Implement Program safeguards for BBA provisions: Create a therapy service program safeguards contractor (PSC)	Develop error rate for therapy services claims	DynCorp, the Comprehensive Error Rate Testing PSC, will produce an error rate for therapy services for years 1998, 1999, 2000. These error rates may be available by February 2003.
4. Promote Provider Integrity	Reduce the rate of return in the provider enrollment process by 30 percent.	Goal not met. Provider enrollment regulation not published. Goal continued in MIP7-04
5. Assure millennium contingency planning	Form contingency planning workgroups for Y2K	Goal met.
6. Inpatient hospital care	Reduce the payment error rate for inpatient hospital claims	FY 2001: 2.79% Goal not met. Baseline: 2.54% (1998)

MEDICARE INTEGRITY PROGRAM

PI Comprehensive Plan Performance Sub-goal	Target	Actual Performance
7. Congregate Care	Develop a data exchange analysis project with Medicare contractors and Medicaid State agencies to allow the coordinated monitoring of services provided to Medicare and Medicaid beneficiaries in congregate care settings	CMS contract with NHIC, however, this part of the project is on hold pending funds availability.
8. Managed Care	Implement the Enrollment Certification Contractor (ECC) and the Managed Care Program Safeguards Contractors (MCPSC)	Goal met. A PSC contract awarded to CMRI on 11/22/00 to perform managed care payment validation. A full and open competition was sponsored by CMS to create a schedule of Medicare Managed Care Program Integrity Contractors. Eight of these contracts were awarded earlier this year. ECC functions will be assumed by these new managed care contractors.
9. Community Mental Health Centers (CMHCs)	Reduce the payment error rate for CMHCs to 39 percent	10 point plan to address abuses implemented. Pending funds availability, a PSC will reevaluate the error rate for FY 2001.
10. Nursing Homes	Decrease the prevalence of pressure ulcers and restraints in nursing homes	See goals QSC1-04 and QSC2-04.

Performance Discussion

By developing and publicly distributing the Comprehensive Plan, CMS reinforced its commitment to fighting fraud and abuse in the Medicare and Medicaid programs. Promoting the integrity of Medicare and Medicaid is a top priority for CMS. As these programs have grown in size and complexity, so have the importance and challenges of that responsibility.

Achieving program integrity now requires the active involvement of every component of CMS, and effective coordination with our partners, including contractors, providers, beneficiaries, law enforcement, and others. Our overarching program integrity goal is straightforward. We strive in every case to pay the right amount, to a legitimate provider, for covered, reasonable, and necessary services, provided to an eligible beneficiary: to pay it right the first time.

In order to achieve this overarching goal, CMS's Comprehensive Plan addressed ten areas. Five of the initiatives in the Comprehensive Plan addressed program management vulnerabilities and the other five addressed specific service areas that we believed were vulnerable to fraud and abuse. The CMS began work on these initiatives in October 1999 and these initiatives were fully implemented in FY 2001. To assist us in evaluating the effectiveness of our efforts, we developed specific performance measures for each of the ten Comprehensive Plan initiatives.

 MEDICARE INTEGRITY PROGRAM

Comprehensive Plan Sub-Goal Updates

(1) Increase the Effectiveness of Medical Review and Benefit Integrity Activities -- Plans for improvement in this area include increasing the overall level of medical review; hiring outside contractors to evaluate medical review practices and workloads across contractors; developing improved performance standards for contractor program integrity activities; and, conducting training for CMS and contractor staff to enhance the quality of fraud case referrals.

Goal (1a): Improve quality of medical review and benefit integrity outcomes.

Baseline: Current quantitative Medicare carrier and fiscal intermediary program integrity performance measurement process.

FY 2001 Target: To develop and fully implement Medicare carrier and fiscal intermediary program integrity performance standards that measure quality and desired outcomes.

Update

Information: New Contractor Performance Evaluation (CPE) guidelines that focus on measuring quality outcomes have been developed and fully implemented. These guidelines were first tested during FY 1999. They were revised in FY 2000 and further streamlined for use in FY 2001. **Goal Met.**

Goal (1b): Develop new methods to reduce the percentage of improper payments made under the Medicare fee-for-service program.

Baseline: The three proposed methods described in the target are new.

FY 2001 Target: To implement the Provider Compliance Rate (PCR); to implement the refined CFO audit methodology to produce a subnational error rate; and to implement a fraud rate program.

Update

Information: See goal MIP2-03 update.

(2) Implement the Medicare Integrity Program -- The CMS is using its more flexible contracting authority to begin contracting with new entities called Program Safeguard Contractors (PSCs). The CMS has awarded 13 PSC contracts and between September and November of 1999 CMS awarded six program integrity task orders to these new contractors.

Goal: Implement a fully functioning Program Safeguard Contractor (PSC).

Baseline: Currently none of the three PSC modes are fully implemented. Additionally, there is no awarded contract for the full PSC model.

FY 2001 Target: To fully implement the following three PSC operational models: a functional model, data analysis model, and a benefit model. In addition, our goal is to award a PSC contract for the fourth PSC operational model, a full PSC model.

 MEDICARE INTEGRITY PROGRAM

Update

Information: We have implemented the three PSC operational models and have awarded the contract for the fourth PSC model. **Goal Met.**

Functional model:

Western Integrity Center: awarded to CSC 7/14/00 - fully operational

Benefit Integrity Support Center: awarded to EDS 11/24/99 - fully operational

Data Analysis Model:

Statistical Analysis Center: awarded to DYNCorp. 3/14/00 - fully operational

Benefit Model:

Therapy Service PSC: awarded to DYNCorp. 8/14/00 - fully operational

Full PSC Model:

DME PSC: awarded to TriCenturion 11/18/00 – fully operational 10/01

(3) Implement Program Safeguards for BBA Provisions -- The Balanced Budget Act of 1997 (BBA), created several new programs, benefits, and payment systems. Payment safeguards must be built into each of these prior to implementation. A variety of efforts are underway within CMS to prevent fraud in these new programs before it happens.

Goal (3a): Establish (1) a national database of State statutes concerning non-physician practitioner licensure requirements, and (2) a process to measure the non-physician practitioner error rate.

Baseline: Currently, there is no national database of State non-physician practitioner licensure requirements, nor is there a claims payment error rate for these services.

FY 2001 Target: Fully implement a national database of State licensure requirements for non-physician practitioners and to pay 90 percent of non-physician practitioner claims correctly.

Update

Information: We have created a database of State licensure requirements. We plan to roll this information out to the Medicare carriers and fiscal intermediaries no later than September 2002. Additionally, pending funds availability, with the implementation of the Comprehensive Error Rate Testing program we will create a non-physician practitioner paid claims error rate. However, at this time, this project is on hold.

Goal (3b): Create a therapy service Program Safeguards Contractor (PSC).

Baseline: Currently, no therapy service PSCs exist, nor is there an established error rate for therapy service claims.

FY 2001 Target: To develop an error rate for therapy service claims.

 MEDICARE INTEGRITY PROGRAM

Update**Information:**

The Therapy PSC contract was awarded to DYNCorp on August 14, 2000. This contract will end in the fall of 2002, however the error rate task was transferred to the Comprehensive Error Rate Testing (CERT) PSC. The CERT PSC will produce the first therapy paid claims error rate for years 1998, 1999 and 2000 by February 2003. In future years, the error rate for therapy services will continue to be produced by the CERT PSC.

(4) Promote Provider Integrity -- Enrolling only high quality providers is key to assuring program integrity. Plans are underway to develop stricter standards and stronger conditions of participation, conduct on-site visits to verify legitimacy and compliance with standards, increase the frequency of re-enrollment, create a national provider enrollment database, establish surety bond requirements, collect Social Security numbers to improve accountability, and collect better ownership and financial solvency information.

Goal: Improve the provider enrollment process.

Baseline: 70 percent rate of return

FY 2001 Target: Reduce the rate of return by 30 percentage points to 40 percent.

Update**Information:**

We will not meet this goal because we have not been able to take the steps necessary in FY 2001 to improve the enrollment process. First and foremost, while the provider enrollment form has been published in the Federal Register, the provider enrollment regulation has not yet been published. We are planning to implement the new form after final Federal Register publication of both the form and the regulation. Additionally, due to funding constraints, the Provider Enrollment Chain Ownership System (PECOS) is not yet implemented. This goal will continue as a stand alone goal for future years (See goal MIP7-04).

(5) Assure Millennium Contingency Planning -- With the advent of the new millennium, Medicare and Medicaid must continue to maintain fiscal integrity. We formed contingency planning workgroups and conducted extensive millennium related business analysis and risk analysis. We spent Summer 1999 testing our contingency plans. **Goal met.**

(6) Inpatient Hospital Care -- Inpatient hospital claims comprised at least 20 percent of the errors identified in the FY 1996, FY 1997, and FY 1998 CFO audits. These errors are particularly significant because they tend to be large claims. The CMS has developed a multi-faceted corrective action plan to reduce these errors, including the development of an inpatient claim Payment Error Prevention Program.

Goal: Reduce the payment error rate for inpatient hospital claims.

 MEDICARE INTEGRITY PROGRAM

Baseline: 2.54 percent (FY 1998)

FY 2001 Target: 2.79 percent.

Update

Information: The FY 1998 baseline has been established. The net payment error rate is approximately 2.54 percent. The FY 2000 net payment error rate is 2.56 percent. We will continue to monitor this error rate and develop corrective actions aimed at reducing the rate.

Goal not met.

(7) Congregate Care -- Groups of beneficiaries gathered in one place, such as a skilled nursing facility, assisted living facility, or adult day care program, become easy targets for unscrupulous providers. Combating this type of fraud requires action on a range of fronts, and a series of proposals is being evaluated. These include assessments of CMS data and systems requirements necessary to understand these types of abuses, adjusting performance measures, and education efforts targeting congregate care facilities.

Goal: Develop a data exchange and analysis strategy to monitor the services provided to Medicare/Medicaid beneficiaries in congregate care settings.

Baseline: System does not currently exist.

FY 2001 Target: Develop and complete a data exchange analysis project with Medicare contractors and Medicaid State agencies to allow the coordinated monitoring of services provided to Medicare/Medicaid beneficiaries in congregate care settings.

Update

Information: The CMS is contracting with National Heritage Insurance Corporation (NHIC) to conduct data matching and associated fraud and abuse review activities, utilizing data it presently warehouses from both Medicare and Medicaid programs operating in the State of California. The computer matching agreement has been approved, however, the congregate care project proposal is currently on hold pending funds availability.

(8) Managed Care -- This initiative consists of three types of tasks: 1) implementation of Medicare+Choice (M+C) program integrity provisions as required under the Balanced Budget Act of 1997, 2) ongoing monitoring of M+C contractors, and 3) development of a Statement of Work (SOW) for one or more managed care program safeguard contractors (PSCs). The purpose of this goal is to fully implement two new types of contractors--the Enrollment Certification Contractor and the Managed Care PSC(s)--to assist us in accomplishing the three tasks defined in the Managed Care Program Integrity initiative.

Goal: Creating Additional Contractors for Managed Care.

Baseline: Currently there is no Enrollment Certification Contractor (ECC) and there are no Managed Care PSCs.

FY 2001 Target: Fully implement the Enrollment Certification Contractor and the Managed Care PSCs.

 MEDICARE INTEGRITY PROGRAM

Update

Information: On November 22, 2000 CMS awarded a contract to CMRI, a PSC contractor, to perform managed care payment validation work. Additionally, CMS met its goal and awarded contracts to eight Medicare Managed Care Program Integrity Contractors. There will not be a separate procurement for an Enrollment Certification Contractor. Instead, this work will be assumed by the Medicare Managed Care Program Integrity Contractors. **Goal met.**

(9) Community Mental Health Centers – The CMS plans a series of actions to strengthen oversight over this benefit. We have already begun a site-visit program to assess the compliance of CMHCs with Medicare rules, and plan to continue this effort. We will be issuing a clarification of the requirements applicable to CMHCs entering the program and subjecting new applicants to increased scrutiny, intensifying medical review for partial hospitalization claims, and increasing our audits of CMHC cost reports.

Goal: Reduce the payment error rate for Community Mental Health Center (CMHC) Partial hospitalization Claims.

Baseline: 90 percent error rate in 1996

FY 2001 Target: 39 percent error rate

Update

Information: The CMS has fully implemented its 10-point plan to address the abuses identified in the CMHC setting. Based on the success of these efforts we expect to meet our error rate reduction target for FY 2001. Pending funding availability, a PSC will re-evaluate the CMHC error rate for FY 2001.

(10) Nursing Homes – The CMS plans several steps to improve the quality of care in the nursing home setting. We will impose sanctions more swiftly and increase the number of site inspections for repeat offenders, enhance Federal review and training for State inspection agencies, and continue building our national automated data system. Survey results will be posted on the Internet to increase accountability and flag problem providers for families and the public.

Goal: Decrease the prevalence of pressure ulcers in nursing homes. (For additional information, see goal QSC2-04).

Baseline: 9.8 percent

FY 2001 Target: 9.6 percent prevalence of pressure ulcers in nursing homes

Update

Information: See QSC2-04.

Goal: Decrease the prevalence of restraints in nursing homes. (For additional information, see goal QSC1-04).

Baseline: 1996 - The mean prevalence of the use of physical restraints among all nursing homes in CY 1996 was 17.2 percent.

MEDICARE INTEGRITY PROGRAM

FY 2001 Target: Maintain a prevalence of the use of physical restraints at less than 10 percent.

Update Information: See QSC1-04.

 MEDICARE INTEGRITY PROGRAM

Performance Goal MIP5-03
Improve the Process of Credit Balance Recoveries
(Discontinued after FY 2003)

Baseline: Incomplete information regarding credit balance-reporting process.
FY 2003 Target: To fully implement revised processes and controls in contractor credit balance activities.
FY 2002 Target: Develop improved processes and controls to be utilized by all contractors to ensure consistency and timely recoveries.
Performance: Goal met. Developed improved processes. These processes are going through internal clearance prior to full implementation in FY 2003.
FY 2001 Target: Gather information on 1) provider credit balance identification, submission and resolution process; and 2) contractor monitoring and resolution of credit balances.
Performance: Goal met. A Final Review Summary Report and a Final Summary Management Overview Report are now available.

Discussion: Studies performed by CMS and the Office of Inspector General (OIG) indicate that approximately 90 percent of credit balances are mainly attributable to provider billing practices. The intent of the mandatory Medicare credit balance reporting requirements is to ensure that Medicare properly recovers improper or excess program payments resulting from patient billing or claims processing errors. Providers must: 1) maintain, during the admission process, a system that identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented; 2) bill other primary payers before billing Medicare except in certain liability situations; and 3) reimburse Medicare within 60 days if the provider receives payment for the same services from another payer. The HCFA-838 report must be completed quarterly by all hospitals and other health care facilities participating in the Medicare program to help ensure that monies owed to the Medicare program are repaid in a timely manner.

Providers who fail to follow these requirements risk losing participation in the Medicare program. Additionally, CMS instructions, in combination with regulations, furnish fiscal intermediaries (FIs) with the authority to sanction providers by suspending program payments if providers do not report credit balances on a quarterly basis. Medicare instructions require providers to follow specific procedures for credit balance reporting in order to guarantee recovery of any reported credit balances.

The CMS's initial review of the FI quarterly credit balance reports indicated that a high percentage of providers submit the HCFA-838 with a zero dollar credit balance. This is possible because the HCFA-838 provides a "snapshot" of the provider's credit balance activities rather than an ongoing view. However, CMS is vulnerable under this snapshot approach because it has no way to determine whether or not a zero balance on the HCFA-838 represents a very tightly run system or a provider that cleans up its credit balance accounts immediately before submitting the HCFA-838 each quarter (including situations where a provider zeroes out its credit balances, but does not make appropriate refunds to

MEDICARE INTEGRITY PROGRAM

the Medicare program). The CMS has identified instances where providers received two payments for the same service, but the provider reported a zero dollar credit balance during that period. Additionally, we identified providers that submitted the HCFA-838 timely and identified a credit balance, but did not submit adjustment requests or send in a check as repayment.

Providers that do not adhere to the reporting requirements of the credit balance report reduce potential savings to the Trust Funds. Due to limited resources and funding available to CMS, only a small percentage of providers can be audited each year. Credit balance reports may not be audited or reviewed for several years because they are only audited during onsite reviews.

Currently, CMS has no database with information specific to credit balance recoveries. This includes a lack of data on the timeframe within which reported credit balances are recovered through adjustment or payment by check.

Approaches include: 1) provider education (as well as attorney and insurer education); 2) instructions to the FIs to strengthen their analysis of the credit balance reporting overall and to specifically look at providers with a continuous zero dollar credit balance; 3) an increase in field audits with a strengthened review of credit balance reporting overall, including special emphasis on those providers with continuous zero dollar credit balance reporting; and 4) use of an independent contractor for data collection and analysis.

To reach our FY 2001 target, a consulting firm was used for data collection and analysis of 6 regional offices, 6 fiscal intermediaries and 24 providers. The methodology, observations, summaries and recommendations are now available in a Final Review Summary Report and a Final Summary Management Overview Report for use by CMS in the improvement of the credit balance recovery process.

To reach our FY 2002 target we revised instructions to both the contractor and the provider to ensure a clear understanding of each party's role and responsibility in the credit balance process. These revised instructions are under internal review. We plan to issue and implement them in FY 2003. Firms that specialize in identifying provider debts to third party payers have argued that providers frequently fail to identify and repay debts to Medicare. In order to gather evidence of this statement, CMS had executed task orders with two recovery contractors under contract with the General Services Administration (GSA) for government wide debt identification and collections activities. These recovery contractors were to audit selected hospitals to identify credit balances identified by the hospital but previously unreported to Medicare. The contractors were allowed to select a total of ten hospitals from a list supplied by CMS. One of the contractors asked to be released from the contract after auditing only three hospitals and finding no unreported credit balances. The other contractor did complete its audit of 10 hospitals and was able to identify some unreported credit balances. However, the number of unreported credit balances identified and the dollar amounts do not substantiate the need for further contracting of this function.

MEDICARE INTEGRITY PROGRAM

Coordination: The CMS, and the FIs will coordinate and monitor the efforts on this GPRA goal.

Data Source(s): Any increased recoveries will be reflected within financial statements as well as savings reports. A Final Review Summary Report and Final Summary Management Overview Report prepared by an independent contractor are now available. We will investigate the possibility of implementing tracking requirements specific to credit balance recoveries.

Verification and Validation: We rely on our contractors to report on their progress with credit balance activities. Their performance and data are evaluated through our Contractor Performance Evaluation Program.

MEDICARE INTEGRITY PROGRAM

Performance Goal MIP6-04

Assess Program Integrity Customer Service

Baseline: Program integrity customer service surveys are new; therefore baseline data do not exist.

FY 2004 Target: A survey of providers and beneficiaries will be conducted. Data from the survey will be used to identify weaknesses and develop a corrective action plan to deal with those weaknesses.

FY 2003 Target: A survey of providers and beneficiaries will be conducted. Data from the survey will be used to identify weaknesses and develop a corrective action plan to deal with those weaknesses.

FY 2002 Target: A survey of providers and beneficiaries will be conducted. Targets and a baseline will be developed from these data.

Performance: Goal met. A corrective action plan has been developed.

Discussion: The CMS is developing a goal to measure and ultimately improve customer satisfaction with the manner in which our program integrity (PI) activities are conducted. This goal focuses on CMS's PI activities with respect to two distinct groups: the provider community and the beneficiary community.

The provider community interacts with CMS and its contractors in many ways. The enrollment process is viewed as burdensome by many providers due to the amount of information that must be supplied. Providers have voiced concern that they do not receive consistent feedback from CMS and its contractors regarding billing issues. They have expressed concern that simple billing errors can result in criminal findings. With respect to the provider community, the aim of this goal is to ensure that the subject of a PI-related review is satisfied with the manner in which their case was handled, even though they may not be satisfied with the outcome.

The CMS, in partnership with the American Association for Retired Persons (AARP), has encouraged beneficiaries to be aware of services billed on their behalf and to report any instances of suspected fraud. In many cases the beneficiary is reluctant to contact CMS or the contractor about a provider. They may fear retaliation or have loyalties, which create ambivalence. With respect to the beneficiary community, this goal will strive to ensure that their contacts are handled in a courteous, professional and attentive manner.

In pursuit of this goal, a contractor will coordinate focus groups, develop and perform surveys, and assist Medicare contractors in the development of customer service plans. The surveys will include, but not be limited to, provider enrollment activities, providers who have been the subject of medical reviews and cost report audits, and beneficiaries who have reported Medicare fraud complaints.

MEDICARE INTEGRITY PROGRAM

Once the survey and focus group data collection is complete, we will analyze the results and develop specific measures for this goal. The measures will quantify and track responses to survey questions and issues raised in focus groups. The results will help us determine the areas in which we should improve our service delivery.

Coordination: The CMS will work closely with its contractors and other stakeholders (e.g., AARP, American Medical Association, American Hospital Association) in carrying out this goal.

Data Source: Information collected from focus groups and surveys will be the primary data source for this goal.

Verification and Validation: The contractor carrying out the surveys and focus groups will be responsible for implementing quality assurance and standard protocols to ensure reliability of the data.

MEDICARE INTEGRITY PROGRAM

Performance Goal MIP7-04**Improve the Provider Enrollment Process**

Baseline: Current data sources for information on the enrollment process are limited, which is why we are developing a national enrollment system.

FY 2004 Target: Continued implementation of PECOS and revalidating 25 percent of Part A and Part B providers/suppliers currently enrolled in the Medicare program using the new streamlined process.

FY 2003 Target: Implementation of PECOS and revalidating 20 percent of Part A providers currently enrolled in the Medicare program using a new streamlined process. This revalidation target will help capture those providers that entered Medicare using the CMS-855 enrollment form or that entered Medicare prior to the use of the CMS-855 enrollment form.

FY 2002 Target: Develop PECOS, implement the revised CMS-855 enrollment form and the regulation pertaining to establishing and maintaining billing privileges.

Performance: PECOS was made available on July 29, 2002, for the fiscal intermediaries to begin populating the system with data from new applications (Goal met). The regulation is in the final stage of the clearance process and the revised CMS-855 forms are pending the release of the regulation. (Goal not met.)

Discussion: This goal is aimed at improving the certified provider enrollment process at the Medicare contractors. One of our key program integrity goals is to ensure we make payments to legitimate providers. This reduces the resources necessary to chase after improper payments. The goal of provider/supplier enrollment is to ensure that only qualified and legitimate individuals and entities receive the right to participate in the Medicare program.

By the end of FY 2002, we intend to have a streamlined and more uniform process of revalidating applications from certified providers for Medicare that will continue to promote the type of payment safeguards we implemented in 1996-1997 with the first nationally standardized enrollment application process.

With the implementation of the new CMS-855s, the Provider Enrollment Chain Ownership System (PECOS), and the "Enrollment Regulation," CMS and its contractors will have the ability to obtain a complete nationally formulated online standard history of any provider or supplier that has or had a business relationship with the Medicare program and the role or roles the individual or organization played in that relationship (e.g., physician, owner, manager, billing agent, etc.).

Coordination: The CMS will work closely with its Medicare payment contractors in carrying out the activities associated with this goal.

Data Source(s): Current data sources for information on the enrollment process are limited, which is why we are developing a national enrollment system. For this goal, we

MEDICARE INTEGRITY PROGRAM

(Provider/Supplier Enrollment Application) into PECOS. As all new enrollments are entered into PECOS, PECOS will track the workflow from data entry to final disposition. PECOS is expected to be implemented for the fiscal intermediaries by the close of FY 2002 and for the carriers by the second quarter FY 2003.

Verification and Validation: We use annual contractor performance evaluation protocol to assess Medicare contractor provider enrollment activities. PECOS data will be verified during annual, onsite surveys of contractors.

 MEDICARE INTEGRITY PROGRAM

Performance Goal MIP8-04

Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Match Agreements with Insurers or Employers

Baseline: As of FY 2002, CMS has negotiated six (6) Voluntary Data Match Agreements (VDMAs) with employers and insurers
FY 2004 Target: Sign two (2) additional VDMAs.

Discussion: The purpose of this goal is to increase the number of VDMAs that CMS has with large employers and insurers for the purpose of exchanging employer or insurer health plan enrollment information for Medicare eligibility information. These data exchanges allow CMS to identify those Medicare beneficiaries who have group health coverage via their employment or via their spouse's employment. Medicare pays secondary in those situations where the beneficiary has group health plan coverage based on his/her own, or a family member's current employment. The VDMA allows CMS to receive this health plan coverage information from employers or insurers on a current (quarterly) basis, which enables Medicare to correctly process Medicare claims for primary or secondary payment. For employers, a VDMA can be used to satisfy their statutory obligation, under 42 U.S.C. § 1395y(b)(5)(c), to complete questionnaires resulting from the IRS/SSA/CMS Data Match process; and to provide that information to CMS on a more current basis.

Employers and insurers often do not know if their non-working enrollees under the age of 65 also have Medicare coverage, so they continue to make primary payments for individuals for whom Medicare is primary. The VDMA also allows employers and insurers to receive Medicare eligibility information for their insured who are not currently working. As part of the VDMA process, employers/insurers can send CMS basic identifying information on an individual they insure and CMS can identify those people entitled to Medicare including basic entitlement information such as periods of entitlement and the beneficiary's Health Insurance Claim Number.

The quarterly, mutual exchange of employee/insurer coverage information for Medicare eligibility information enables all parties to correctly process claims for primary and secondary payment. Additional benefits to CMS include: (1) a significant reduction in costs and administrative efforts associated with dispute resolution and recovery of mistaken primary payments, (2) lower long term operating costs for collection and storage of employer coverage data than via the IRS/SSA/CMS Data Match Project, (3) more accurate coverage data on a current basis and (4) increased customer service to beneficiaries and our Medicare partners.

Many of the advantages of VDMAs to CMS also apply to employers/insurers. An additional significant advantage for employers is that, if they sign a VDMA, they are excused from completing the annual IRS/SSA/CMS Data Match Questionnaire. Employers complain that the IRS/SSA/CMS Data Match can be costly, is difficult to plan

 MEDICARE INTEGRITY PROGRAM

and budget for, and requires them to retrieve archived coverage information. Many employers have asked if there is a better way they could provide CMS with employee and spousal coverage information. The alternative is signing a VDMA. The CMS also benefits from having the employer submit employee coverage information via the VDMA. Rather than waiting the up to two and a half years it takes to identify potential working beneficiaries and their spouses via the IRS/SSA/CMS Data Match, CMS gets current coverage data every quarter directly from the employer/insurer. As previously stated, more timely coordination of benefits reduces expense and hassle to CMS, our partners and Medicare beneficiaries associated with CMS's attempts to recover mistaken Medicare primary payments by enabling Medicare to pay correctly the first time a claim is submitted for payment.

The CMS has made great strides to sign VDMS with large employers/insurers. The resources required to electronically exchange information with CMS on a cost effective basis limit the potential market for VDMS to very large employers and insurers. Currently, CMS has four signed employer VDMS (AT&T, Lucent Technologies, General Electric, and Ford Motor Company), and is actively negotiating with several others. The CMS currently has one signed insurer voluntary agreement with Uniprise (United Health Care Insurance Company of New York – Empire Plan for Hospitals) and one agreement that has been signed by over forty private-side BCBSA Plans. With the recent signing of the BCBSA and Uniprise agreements covering such a large enrollee population, we anticipate CMS will sign additional insurer agreements. Inquiries have increased from other large insurers which represent significant sources of MSP information.

In addition to numerous print, mail and website promotions of VDMS, CMS and the Coordination of Benefits (COB) Contractor have hosted or participated in numerous employer conferences and outreach programs. Due to these marketing efforts and word of mouth from current participants, requests for information about VDMS has increased.

Coordination: The CMS will continue to work with its COB Contractor and other private and public partners to develop new ways of marketing VDMS. The mutual benefits of these agreements help VDMS to sell themselves to larger employers and insurers. However, given the size of the entities CMS seeks for this effort and the systems changes they must make to participate in this electronic data exchange, these agreements are usually protracted, with many internal and external variables affecting how many can be finalized in a given period. The CMS will continue to supervise the COB Contractor's promotion of VDMS to employers/insurers as an alternative to the IRS/SSA/CMS Data Match and will monitor and actively support the efforts toward achieving this GPRA goal.

Data Source(s): The CMS receives the Medicare Secondary Payer (MSP) data from those entities, identified above, that currently have a VDMA with CMS. The employer/insurer sends its files to the COB Contractor for processing in the prescribed CMS format, and files containing information on covered working individuals are

MEDICARE INTEGRITY PROGRAM

transferred to CMS. The COB Contractor also processes the separate eligibility inquiry file sent by employers/insurers through the Enrollment Data Base to obtain the necessary Medicare entitlement information. The CMS does not use any of the data submitted in the employers eligibility inquiry file to update any of Medicare's records. Each file submission results in its own separate response file being sent back to the employer.

Verification and Validation: The COB Contractor edits and validates the data received by the employers/insurers through multiple independent processes before uploading any new MSP information to the Common Working File, a CMS database used in the claims adjudication process. All records with an error are identified and sent back to the employer/plan indicating why the record could not be processed. Records that do not contain errors are processed accordingly.

MEDICARE INTEGRITY PROGRAM

Performance Goal MIP9-04**Reduce the Medicare Contractor Error Rate**

Baseline: Developmental.
FY 2004: Set Baseline

Discussion: The CMS implemented the Comprehensive Error Rate Testing (CERT) program in 2002 and is using the CERT methodology to develop the national fee-for-service error rate with greater precision than the previous OIG audit method. In addition, CERT will produce contractor, provider and benefit-specific error rates. The CERT program will provide substantially greater detail and analysis of vulnerabilities in the current system, which will help focus corrective actions.

CERT is a tool that CMS wants contractors to use to develop their medical review and provider education and training strategies. Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers. CERT will be used to establish the baseline error rates. Once a baseline is created, CMS will be able to track whether the corrective actions undertaken by the contractor are affecting their error rate. CERT is being used in the contractor performance based contracting pilots as a metric.

For each Medicare contractor, Medicare will conduct reviews for a statistically valid sample of claims and determine whether the contractor paid the claim accurately. The review will determine whether health care providers were underpaid or overpaid for the sampled claims. The results will reflect not only the contractor's performance, but also the billing practices of the health care providers in their region.

The results will lead to a contractor-specific error rate that Medicare will track to promote improvements. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claims review and other activities.

By FY 2008, CMS intends to have all Medicare claims processed by contractors that have an error rate of 5 percent or less. Critically important in reducing the contractor error rate is determining the root causes of error. Some errors may be caused by claims processing systems, unclear policies or CMS technical requirements. The CMS will use the information obtained through this process to revise policies and instructions, and institute systems changes, as well as use CERT as a measure of performance.

Our goal by FY 2008 is for all Medicare contractors to have an error rate of 5 percent or less. We are proposing the following annual targets:

FY 2005: 25 percent of Medicare claims will be processed by contractors who have a 5 percent or better error rate;

MEDICARE INTEGRITY PROGRAM

- FY 2006: 50 percent of Medicare claims will be processed by contractors who have a 5 percent or better error rate;
FY 2007: 75 percent of Medicare claims will be processed by contractors who have a 5 percent or better error rate.

Once baseline data is received, CMS will evaluate these targets and modify as necessary to meet the primary goal.

Coordination: We will continue to work with OIG, our program safeguard contractors (PSC), and our Medicare contractors to develop the projects identified in this goal.

Data Source: Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers.

Verification and Validation: The CMS verifies contractor performance and data through its Contractor Performance Evaluation program. In addition, the OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.

 MEDICARE INTEGRITY PROGRAM

Performance Goal MIP10-04**Improve the Medicare Provider Compliance Rate**

Baseline: Developmental
FY 2004: Set baseline.

Discussion: The Provider Compliance Rate (PCR) is a method of determining a “compliance rate” among providers based upon a random sample of submitted claims. The sampled claims are subjected to detailed medical review and a compliance rate is calculated based upon the dollar value ratio of valid claims submitted correctly to total claims. PCR was implemented during FY 2001 as part of the Comprehensive Error Rate Testing (CERT) program at all Medicare contractors. PCR is expected to further enhance medical review effectiveness and promote provider compliance.

CERT is a tool that CMS wants contractors to use to develop their medical review and provider education and training strategies. Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers. CERT will be used to establish the baseline provider compliance rates. Once a baseline is created CMS will be able to track whether or not the corrective actions undertaken by the contractor are affecting their provider compliance rate with providers.

Our goal by 2008 is to significantly improve the provider compliance rate. We are proposing the following annual targets:

2005: Increase the PCR 20 percent over the 2004 level.

2006: Increase the PCR 20 percent over the 2005 level.

2007: Increase the PCR 20 percent over the 2006 level.

Once baseline data is received, CMS will evaluate these targets and modify as necessary to meet the primary goal.

Coordination: We will continue to work with OIG, our PSC contractors, and our Medicare contractors to develop the projects identified in this goal.

Data Source: Contractors receive a monthly error rate report from the CERT contractor and can use the information on a monthly basis to look for trends and outliers.

Verification and Validation: The CMS verifies contractor performance and data through its Contractor Performance Evaluation program. In addition, the OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.

 MEDICARE INTEGRITY PROGRAM

Performance Goal 27-00

**Reduce the Percentage of Medicare Home Health Services Provided for which
Improper Payment is Made
(Discontinued after FY 2000)**

Baseline: A 1997 report by the HHS Office of the Inspector General (OIG) on home health agencies revealed that, in four of the five States reviewed by the OIG as part of Operation Restore Trust (ORT), payments for 40 percent of Medicare home health services should not have been made. In generating this report, the OIG reviewed a sample of 1995 and 1996 paid claims data collected over a 15 month period which ended March 31, 1996.
FY 2000 Target: Reduce the home health error rate from 35 to 10 percent in California, Illinois, New York, and Texas by taking specific corrective actions, including implementing the home health provisions of the Balanced Budget Act of 1997.
Performance: Goal not met.
FY 1999 Target: Reduce the home health error rate from 40 percent to 35 percent.
Performance: Goal met.

Discussion: In 1997, the OIG of the Department of Health and Human Services (HHS) reported that nearly 40 percent of home health services provided in California, Illinois, New York, and Texas (which in 1995 represented nearly 28 percent of all nationwide home health agency reimbursements) did not meet the Medicare requirements for payment. Further, the report examined paid home health claims to determine whether services were delivered and if they met Medicare's criteria for payment. A random sample of claims during the 15-month period ending March 31, 1996 was reviewed, indicating specifically from on-site OIG staff reviews, that claims were improperly paid.

In FY 1999, the OIG repeated its evaluation of home health claims, using a sample of paid home health claims from January 1, 1998 to September 30, 1998 in the same four States, and determined that CMS's activities successfully reduced the home health claims payment error rate from 40 percent to 19 percent, exceeding the CMS goal of reducing the error rate in 1998 to 35 percent.

To accomplish this goal, CMS developed and implemented tools to fight fraud and abuse in the Medicare home health program that: strengthened the Agency's ability to identify problem home health agencies; prevented them from entering into the program; reduced losses to the Medicare program due to problem home health agencies; and, prevented inappropriate payments to providers by restructuring coverage and payment for home health services.

In FY 2001, CMS replicated the OIG evaluation of home health claims for a third and final time, using a sample of paid home health claims from January 1, 1999 to September 30, 1999 in the same four States, to determine if CMS's activities further reduced the rate of improper payment. Results indicate that the error rate was not reduced further; that in fact the error rate increased by approximately 10 percent resulting in a home health claims payment error rate of 29.5 percent. We believe that the increased

MEDICARE INTEGRITY PROGRAM

error rate may be due to changes in provider behavior in anticipation of the implementation of the home health prospective payment system in October 2000.

The CMS recognizes the importance of continued efforts to reduce improper home health payments. Our efforts include more effective provider education and payment monitoring activities. The CMS recently awarded a Program Safeguard Contract (PSC) Task Order to assess and recommend measures to improve the accuracy of the Outcome and Assessment Information Set (OASIS), the standardized assessment that is used to determine Medicare payment. Activities under this contract include national surveillance of home health data to identify provider educational needs and payment vulnerabilities. The CMS will continue to monitor the home health claims using the Comprehensive Error Rate Testing (CERT) PSC.

This goal was discontinued in order for CMS to focus on other equally compelling program integrity areas. In FY 2002 and following years, however, CMS will continue its efforts to reduce improper home health payments.

Coordination: Success at reducing home health fraud depends heavily on coordination both within and outside CMS.

Data Source(s): Independent audit of a statistical sample of paid claims was conducted by CMS or its agent.

Verification and Validation: The CMS contracted with an independent agent to evaluate the error rate of paid home health claims for the 9-month period from January 1, 1999 to September 30, 1999.

MEDICARE OPERATIONS

Medicare Operations

Medicare Operations	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Budget Authority	\$1,356.4 M	\$1,532.0 M	\$1,675.1 M	\$1,776.9 M

The Medicare Operations line item primarily funds the traditional Medicare fee-for-service program, mainly through the activities of CMS's Medicare contractors. There are two basic types of contractors: fiscal intermediaries, who process mainly Part A claims (e.g., hospital bills) and carriers who process Part B claims (e.g., physician bills). These contractors are responsible for making timely, accurate, and fiscally responsible payments to Medicare providers and suppliers for covered health care services. In FY 2004, they will process more than one billion Medicare claims; handle more than 8 million appeals; respond to over 45 million inquiries from providers and beneficiaries; enroll, educate, and train providers and suppliers; educate and assist beneficiaries; and perform other responsibilities on behalf of CMS.

The Medicare Operations activity also includes Information Technology funding for critical claims processing functions, such as telecommunications, systems maintenance, and data center support. It funds a variety of projects that enhance the Medicare program and make it more efficient, such as a new accounting and financial management system for the contractors. It also supports major provisions of the Beneficiary Improvement and Protection Act of 2000, and the Health Insurance Portability and Accountability Act of 1996, including Administrative Simplification and the Privacy Regulation. In addition, it funds the National *Medicare & You* Education Program (NMEP), an initiative that educates Medicare beneficiaries so they can make informed health decisions based on accurate, reliable, relevant and understandable information. The Medicare Operations activity funds the major portion of NMEP activities which include: a Medicare handbook with area-specific information on managed care plans, a toll-free number (1-800-MEDICARE), an Internet site (www.medicare.gov), counseling and outreach, and a national ad campaign. Other sources of funding include the Medicare+Choice user fee and Quality Improvement Organization funds.

The CMS's Medicare contractors also serve as the front line in safeguarding the Medicare trust funds against fraud, waste, and abuse. These benefit integrity activities are funded separately through the Medicare Integrity Program budget and are not included in the totals shown above.

Other representative goal(s) that fit under this budget category but are not listed in the chart are:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-04)
- Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program (MIP1-04)

- | Performance Goal | Targets | Actual Performance | Ref. |
|--|---|---|------|
| Improve Beneficiary Telephone Customer Service (Developmental) | | | MO1 |
| --Quality of Response | <p>FY 04: --Minimum of 87% pass rate for Adherence to Privacy Act</p> <p>--Minimum of 90% meets expectations for Customer Skills Assessment</p> <p>--Minimum of 87% meets expectations for Knowledge Skills Assessment</p> | FY 04: | |
| | <p>FY 03: --Minimum of 85% pass rate for Adherence to Privacy Act</p> <p>--Minimum of 90% meets expectations for Customer Skills Assessment</p> <p>--Minimum of 85% meets expectations for Knowledge Skills Assessment</p> | FY 03: | |
| -- Expansion of 1-800-MEDICARE number and desktop rollout | <p>FY 04: Continue expansion efforts</p> <p>FY 03: Begin expansion efforts</p> | <p>FY 04:</p> <p>FY 03:</p> | |

MEDICARE OPERATIONS

Performance Goal	Targets	Actual Performance	Ref.
Increase Use of Electronic Commerce/Standards in Medicare			MO3
-- Maintain high percentage of electronic media claims (EMC) for fiscal intermediaries (FIs)	FY 04: 97% FY 03: 97% FY 02: 97% FY 01: 97% FY 00: 97% FY 99: 97%	FY 04: FY 03: FY 02: 98% (Goal met) FY 01: 97.7% (Goal met) FY 00: 97.4% (Goal met) FY 99: 97.1%	
-- Maintain high percentage of EMC for carriers	FY 04: 80% FY 03: 80% FY 02: 80% FY 01: 80% FY 00: 80% FY 99: 80%	FY 04: FY 03: FY 02: 83.7% (Goal met) FY 01: 83.0% (Goal met) FY 00: 81.9% (Goal met) FY 99: 80.9%	
-- Implement HIPAA standards	FY 04: TBD FY 03: Complete claim status, eligibility inquiry, prior authorization, and retail drug standards implementation and testing. FY 02: Complete implementation of HIPAA EDI standards for claims, COB and ERA. Begin implementation for claims status and eligibility inquiries. FY 01: Begin testing and implementation of HIPAA EDI standards	FY 04: FY 03: FY 02: Completed Medicare implementation of HIPAA EDI standards for claims, COB, and ERA. Implementation for claims status and eligibility inquiries started. (Goal met) FY 01: Instructions for testing and implementation of the HIPAA EDI standards were issued in FY 2001 (except for the eligibility inquiry and response transaction). Due to competing project priorities, implementation and testing of other HIPAA EDI standards needed to be delayed until FY 2002. (Goal not met)	
Develop baseline data for electronic claims status, electronic eligibility queries, ERA, EFT and COB transactions	FY 03: Complete Baseline FY 02: Continue to develop Baseline FY 01: Develop Baseline	FY 03: FY 02: Baseline data collection to begin for carriers effective 04/1/03. Intermediary collection to be scheduled. FY 01: Funding was requested for this work for FY 01 and FY 02 but not available as needed for higher priority projects. As a result, system changes to enable baseline data to be collected was deferred to FY 03.	

MEDICARE OPERATIONS

Performance Goal	Targets	Actual Performance	Ref.
Improve CMS's Rating on Financial Statements	FY 04: Maintain a "clean" opinion on the FY 2004 financial statements. FY 03: Maintain a "clean" opinion on the FY 2003 financial statement FY 02: Maintain a "clean" opinion on the FY 2002 financial statement FY 01: Maintain a "clean" opinion on the FY 2001 financial statement FY 00: Maintain a "clean" opinion on the FY 2000 financial statement FY 99: Achieve a "clean" opinion on the FY 1999 financial statement	FY 04: FY 03: FY 02: (Goal met) FY 01: (Goal met) (NEW DATA) FY 00: (Goal met) FY 99: (Goal met) FY 98: Qualified opinion (Baseline) FY 97: Qualified opinion FY 96: Disclaimer on audit	MO4 
Improve CMS oversight of Medicare Fee-for-Service contractors (Developmental)	FY 04: Developmental FY 03: Building on prior year's experience. FY 02: Building on experience of FY 2001 FY 01: Building on progress achieved in FY 1999 and FY 2000 CMS will move further toward its goal of national, uniform contractor evaluation.	FY 04: FY 03: FY 02: (Goal met.) FY 01: (Goal met) FY 00: Inconsistency in reporting (Baseline)	MO5 5, 8 
Increase eligible delinquent debt referred for cross servicing to the Program Support Center	FY 04: Same as FY 2003 FY 03: --Continue to refer 100% of eligible delinquent CMS receivables to Treasury. --Improve the procedures for identifying, monitoring and tracking these debts. FY 02: Increase dollar amount of debt referred for cross servicing to 100% of eligible delinquent debt	FY 04: FY 03: FY 02: Referred 90% of eligible debt. Remaining debt to be referred first part of FY 2003. (Goal not met) FY 01: \$2.1 billion delinquent debt referred FY 00: We referred approximately \$2 billion in delinquent debt. This equals about 25% of eligible debt (Baseline)	MO6 

MEDICARE OPERATIONS

Performance Goal	Targets	Actual Performance	Ref.
Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service through implementation of the Medicare Summary Notice (MSN)	FY 03: Goal discontinued due to completion of implementation FY 02: Complete national implementation FY 01: Same as FY 2000 FY 00: Support MSN efforts, aiming toward full implementation FY 2002	FY 03: Goal discontinued FY 02: National MSN implementation has been completed (Goal met) FY 01: Carrier/FI MSN implementation at 81%. Contractor support ongoing. (Goal met) FY 00: Carrier/FI MSN implementation at 81% (Goal met) FY 99: Carrier/FI MSN implementation at 75% FY 97: Beneficiaries received various notices indicating claims activity for most Part A and Part B services (Baseline)	MO7
Improve effectiveness of dissemination of Medicare information to beneficiaries (5-year targets): --<u>Accessibility of Information</u> Collect and monitor data to achieve by FY 2004 percentage of beneficiaries who sought Medicare information from Medicare sources and reported the information received answered their question(s). --<u>Awareness of Messages</u> Collect and monitor data to achieve by FY 2004 percentage of beneficiaries who know that most people covered by Medicare may select from among different health plan options within Medicare.	FY 04: 77% FY 03: Collect/monitor data FY 02: Collect/monitor data FY 01: Collect/monitor data FY 00: Collect/monitor data FY 04: 57% FY 03: Collect/monitor data FY 02: Collect/monitor data FY 01: Collect/monitor data FY 00: Collect/monitor data	FY 04: FY 03: FY 02: Data collected/monitored (Goal met) FY 01: Data collected/monitored (Goal met) FY 00: Though single-year MCBS data are not statistically meaningful for this goal, we are on track to meet our target by FY 2004 FY 99: 67% (Baseline) FY 04: FY 03: FY 02: Data collected/monitored (Goal met) FY 01: Data collected/monitored (Goal met) FY 00: Though single-year MCBS data are not statistically meaningful for this goal, we are on track to meet our target by FY 2004 FY 99: 47% (Baseline)	MO8 3, 5  See FY 03 Revised Final

MEDICARE OPERATIONS

Performance Goal	Targets	Actual Performance	Ref.
Improve beneficiary understanding of basic features of the Medicare program by: (1) Increasing number of questions correctly answered by beneficiaries to measure understanding of different components of Medicare (2) Increasing percentage of beneficiaries aware of 1-800 MEDICARE number	FY 04: (1) 3.50 out of 6 questions (2) 65% of beneficiaries FY 03: Continue to collect & monitor data FY 02: Baselines/future targets to be developed FY 01: (1) Develop list of core features (2) Obtain advisory input (3) Design and test survey questions (4) Integrate questions (5) Field questions	FY 04: FY 03: FY 02: Baselines/targets developed (Goal met) FY 01: Steps 1-5 completed. Survey fielded. (Goal met) CY 00: (1) 2.75 out of 6 questions (2) 53% of beneficiaries (Baselines)	MO9 3, 5  See FY 03 Revised Final

Performance Results Discussion

Fee-for-Service Telephone Customer Service – To improve fee-for-service (FFS) telephone customer service, CMS is “raising the bar” with respect to quality standards to keep up with industry norms and customer expectations. Initially for FY 2000-2002, our intent was to measure beneficiary customer service in three areas: accessibility, accuracy of response, and caller satisfaction. Once consistent standards were developed for all contractors, CMS was able to continue to collect data for these measures, meeting our FY 2001 goal. However, due to technical difficulties, our FY 2001 conversion to the FTS-2001 long distance service provider (WorldCom) took longer than expected requiring an extension of the future data collection period for the accessibility measure. Recently, a change in Agency priorities and the strategy for telephone customer service required a redirection of funding for the national caller satisfaction survey to a pilot operation in Pennsylvania (beneficiaries calling a single 800 number), in early FY 2002. This important pilot is a model for how CMS will handle calls in the future, and the future focus of this goal will track the nationwide implementation of this toll free number.

The CMS also made the development and implementation of a standard desktop for customer service representatives (CSRs) at contractor call centers one of its highest priorities in telephone delivery. This desktop, Next Generation Desktop, is scheduled to be rolled out to the call centers during FY 2003 – 2004, and will result in significant improvements in the call centers, by increasing the consistency and accuracy of responses to beneficiary inquiries, ultimately increasing their satisfaction with the telephone interaction. However, given the lack of baseline data and the anticipated initial impact of the new desktop tool, CMS cannot establish realistic performance targets for caller satisfaction for several years to come. This lack of baseline data, along with the change in Agency priorities has resulted in the discontinuation of the caller satisfaction and accessibility measures at this time.

MEDICARE OPERATIONS

Fee-for-Service Medicare Payment Timeliness – For FY 2002, we were successful in achieving payment timeliness of electronic claims at 99.7 percent for intermediaries and 99.5 percent for carriers. We will continue to maintain payment timeliness performance at a level that meets the statutory requirement for payment of electronic claims.

Electronic Commerce – For the FY 2002 Electronic Commerce goal, we were successful in maintaining high percentages of electronic media claims of 98 percent and 83.7 percent for fiscal intermediaries and carriers, respectively. The CMS is performing ongoing work with Health Insurance Portability & Accountability Act (HIPAA) electronic standards development for the health care environment. In FY 2001, we began implementing HIPAA Electronic Data Interchange standards, and continued the work in FY 2002. We will continue our work on implementation of standard transactions in FY 2003.

Programming and preliminary testing for implementation of the HIPAA claim standard was completed in FY 2002. Programming hours and funding to enable completion of implementation and testing for each of the HIPAA standards were unavailable in FY 2001 because of changes in agency project prioritization. As a result, some of the work was deferred until FY 2002 and FY 2003. In addition, due to the complexity of implementation of these standards, contractor programming hour estimates increased resulting in completion of less work, but at a higher cost than initially anticipated. HIPAA requires that the Secretary adopt national health care EDI standards for at least the nine transaction types specified in the legislation. As a result of a redirection of funding and available programming hours, it was not possible to schedule implementation and testing of the transactions for prior authorization and retail drugs until FY 2003. Those standards, as well as work deferred from FY 2001 and FY 2002 as described above, are now included in the targets established for FY 2003.

Chief Financial Officer's Report – The CMS financial statements are a material element of both the Department of Health and Human Services financial statements and the government-wide financial statements required by the CFO Act of 1990 and the Government Management and Reform Act (GMRA). The CMS met its goal to maintain a “clean” unqualified opinion on FY 2002 financial statement.

During FY 2002, we tested financial management internal controls at 15 Medicare contractors using Certified Public Accounting (CPA) firms, conducted contractor performance evaluation reviews of financial management issues at 6 Medicare contractors, and reviewed accounts receivable balances at 12 Medicare contractors using CPA firms. In addition, we continued to develop the analytical tools necessary to perform more expansive trend analysis of critical financial data to identify potential errors or misstatements. Our long-term plan is to implement an integrated general ledger accounting system.

Fee-for-Service Contractor Oversight - In an effort to improve performance and oversight of carriers and fiscal intermediaries (FI) that interact directly with CMS's customers, CMS established several performance goals in this area. The CMS can

 MEDICARE OPERATIONS

provide better oversight of our contractors by using a standardized, uniform evaluation process. In 2001 national teams using standardized review protocols conducted 171 onsite reviews. In 2002, national teams using standardized evaluation protocols conducted 132 onsite reviews. Greater review consistency has been achieved through the increased use of national (regional office/central office) review teams, development and use of standard review protocols, and conducting national conferences and training for reviewers. We are looking forward to continued improvement through the use of performance information to guide our contractor oversight activities.

Delinquent Debt - The CMS worked hard to meet its goal of referring 100 percent of all eligible delinquent debt. However, due to the various manual processes used to track and report Medicare debt, the referral process was more time consuming and labor intensive than originally anticipated. Therefore, the CMS managed to refer approximately 90 percent of its eligible delinquent debt by the end of the fiscal year. The balance of eligible debt will be referred in FY 2003. In order to improve performance, CMS has established workgroups that will assist in identifying various types of debts and establishing improved procedures for referring the debt for cross servicing.

Beneficiary Information/Fee-for-Service (Medicare Summary Notice-MSN) - National implementation of the MSN is expected to improve effectiveness of information for beneficiaries enrolled in the fee-for-service program. Because this monthly information will be in a more clear, understandable format than previous multiple notices, it is also expected to be easier for beneficiaries to spot inconsistencies or instances of fraud. In FY 2001, we supported, and will continue to support, the Medicare contractors that have already implemented the MSN by answering questions, solving problems, considering suggestions, etc. We will also continue to handle Congressional, beneficiary, contractor, and beneficiary advocacy group inquiries relating to the MSN in general and to the resulting confusion beneficiaries may feel due to receiving the MSN in some instances and different benefit notices (Explanation of Medicare Benefits, Notice of Utilization, and Explanation of Benefits) in other instances. We have now met our FY 2002 goal of nationwide implementation of the MSN.

Beneficiary Information - With clear baselines in place, we continue to track our beneficiary education efforts toward our ultimate 5-year target beneficiary accessibility and understanding of educational efforts in the area of the Medicare+Choice program. Feedback from surveys of beneficiaries receiving the *Medicare & You* handbook has been positive, and the number of beneficiaries calling CMS's toll-free number (1-800-MEDICARE) continues to increase with positive feedback. The beneficiary-centered website (www.medicare.gov) also continues to be popular, and data collected from the website's feedback form demonstrate high user satisfaction. These efforts, along with other national and local programs, strive to raise beneficiary awareness from different perspectives; e.g., through the Quality Improvement Organizations' public nursing home campaigns.

In Fall 2001 and 2002, CMS embarked on a national ad campaign which has helped beneficiaries and their caregivers become active and informed participants in their health

MEDICARE OPERATIONS

care decisions. We implemented a number of new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their choices. This included:

- expanding customer service representative availability at 1-800-MEDICARE to 24 hours a day, 7 days a week;
- introducing a web-based Medicare Personal Plan Finder on www.medicare.gov to help consumers compare their health plan choices (M+C plans, Medicare Fee-for-Service, and Medigap plans);
- enabling customer service representatives at 1-800-MEDICARE to provide more in-depth help to callers on finding the health plan choice that is best for them; and
- conducting a national ad campaign on the new choices and new ways to get information.

These strategies will contribute to many important Agency efforts and will support several performance goals, including our goals to improve beneficiary understanding of basic features of the Medicare program (MO9-04) and to increase adult immunization (QIO2-04) and mammography rates (QIO3-04). We plan to conduct another national media campaign in Fall 2003 to continue our promotion of the Medicare program.

Beneficiary Understanding - To promote beneficiary and public understanding of CMS and its programs, we have developed a goal to improve and measure beneficiary awareness of (1) the core features of Medicare needed to use the program effectively, and (2) CMS sources from which additional information can be obtained. We will measure beneficiary awareness and understanding of the Medicare program using the Medicare Current Beneficiary Survey. The first measure is to improve the number of questions about the Medicare program answered correctly out of six questions on a knowledge quiz. The second measure is to improve beneficiary awareness of the 1-800-MEDICARE information number.

MEDICARE OPERATIONS

Performance Goal MO1-04

Improve Beneficiary Telephone Customer Service

Baseline: National quality targets defined. Currently no standardization of telephone call centers; 1 pilot underway.
FY 2004 Target: (1) Quality Standards: --Minimum of 87 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 87 percent meets expectations for Knowledge Skills Assessment (2) Continue national expansion of 1-800-MEDICARE.
FY 2003 Target: (1) Quality Standards: --Minimum of 85 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 85 percent meets expectations for Knowledge Skills Assessment (2) Begin national expansion of 1-800-MEDICARE.
FY 2002: New in FY 2003

Baseline: Developmental. Baseline data on accessibility, accuracy of response, and caller satisfaction are being collected and will be available by the end of FY 2002.
FY 2002 Target: Complete data collection and set baselines/future targets.
Performance: Goal partially met. Accuracy standards were set (see Quality Standards, above). Accessibility and caller satisfaction measures discontinued due to shift in focus in the delivery of beneficiary telephone customer service.
FY 2001 Target: Continue data collection for accessibility, accuracy of response, and caller satisfaction measures (revised due to unavailability of accurate data until FY 2002).
Performance: Goal met. Data collection continuing.
FY 2000 Target: Develop baselines and targets by the end of FY 2000 in areas of accessibility, accuracy of response, and caller satisfaction.
Performance: Goal not met.

Discussion: Medicare carriers handle nearly 18 million telephone beneficiary inquiries annually. Beneficiary telephone customer service is a central part of CMS's customer service function, and we are developing a long-term and comprehensive strategy to deliver efficient, informative and customer-focused telephone service for our beneficiaries.

Although our previous goal (FY 2000-02) focused on measuring improvements in accessibility, accuracy of response, and caller satisfaction, our new goal focuses on the nationwide implementation of a single 800 number for beneficiary inquiries. This shift reflects a significant systems change that will enhance contractor efficiency and also improve responsiveness to our beneficiaries. We will continue to measure the quality standards that we have built over the last few years while we introduce improvements in telephone customer service via the 1-800-MEDICARE line nationwide.

Currently, the 1-800-MEDICARE number is a helpline for general Medicare questions unrelated to specific claims or individual beneficiaries; our planned expansion will allow

 MEDICARE OPERATIONS

personalized customer service via the 800 number. This goal focuses on improvements at the carrier and fiscal intermediary level; these services will ultimately be rolled into a single 800 number that will route customers to the appropriate Medicare contractor call centers. The CMS presently allows each Medicare contractor to have numerous toll-free numbers for managing their Medicare telephone inquiries. This has proven to be confusing to the public and prevents us from managing our call volumes in an orderly and efficient manner. In addition, based on statistics, we answer over 18 million calls a year; however, we receive almost 30 million call attempts a year to all of our toll-free numbers. This means that a large percentage of our calls go unanswered each year. A single 800 number will provide one point of contact for the calling public.

Our long-term strategy will be to make this 800 number a single entry point into the network, providing economies of scale, and to utilize resources by seamlessly shifting from over utilized to underutilized call centers. This will: (1) capture many of the calls that were not getting through, and (2) reduce the number of callers who dial one number and are referred to another (currently, 25 percent of the callers to the 1-800-MEDICARE line are referred to their carrier's 800 number). All call centers will have access to the systems housing beneficiary information and will be equipped with scripts to enable the customer service representatives to handle any question, regardless of which call center is being used. Currently, an 800 number pilot project in Pennsylvania is a model for how CMS will handle calls in the future.

Another critical strategy is the development and implementation of a standard desktop for customer service representatives at the contractor call centers. Customer service representatives at one Durable Medical Equipment Regional Carrier were trained on this desktop in late FY 2002. After it is pilot tested, this desktop will be rolled out to the remaining call centers over the next couple of years. The new desktop tool is designed to increase the consistency and accuracy of all responses to beneficiary inquiries and thus will ultimately increase the customers' satisfaction with the telephone interaction.

Coordination: The CMS will work closely with its contractors during the data collection process for our quality measures and implementation of the desktop toward national implementation of 1-800-MEDICARE.

Data Source(s): As reviewers/auditors monitor a sample of calls for each customer service representative, they record the assessment of performance on standardized Quality Call Monitoring scorecards. Criteria for rating all aspects of call handling are also standardized. Accuracy and overall quality of the calls handled are reported monthly to CMS's Customer Service Assessment and Management System using scorecard totals.

Verification and Validation: Data reported by carriers are routinely reviewed by CMS Regional Offices as part of the contractor performance evaluation process. In addition, contractor reporting is reviewed on a regular basis by CMS for compliance with established standards. The CMS plans to validate the data on accuracy of response by having an independent third party sample a minimum of calls.

 MEDICARE OPERATIONS

Performance Goal MO2-04
**Sustain Medicare Payment Timeliness
 Consistent with Statutory Floor and Ceiling Requirements**

Baseline: In the baseline year FY 1998, intermediaries and carriers, respectively, met statutory requirements that 95 percent of clean, electronically submitted non-Periodic Interim Payment electronic bills and 95 percent of clean, electronically submitted claims are processed between 14-30 days of receipt.
FY 2004 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.
FY 2003 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.
FY 2002 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.
Performance: Goal Met
FY 2001 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.
Performance: Goal Met
FY 2000 Target: Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims in a millennium compliant environment.
Performance: Goal Met

Discussion: The Social Security Act, sections 1816 (c)(2) and 1842 (c)(2) establish mandatory timeliness requirements for Medicare claims payment to providers of services. As a result, Medicare intermediaries and carriers are required to pay 95 percent of clean electronic media bills/claims between 14 to 30 days from the date of receipt. This requirement does not include Periodic Interim Payment bills.

Medicare contractors have traditionally satisfied CMS's bill/claim processing timeliness requirements. Medicare contractors are under added pressure to sustain performance with increased efforts directed at decreasing the number of Medicare payments that are attributed to fraudulent or abusive billing. However, CMS has identified bill/claim-processing timeliness as a priority area. To that end, Medicare contractors are required to maintain the statutory level of bill/claim processing timeliness performance while strengthening their ability to deter fraud and abuse in the Medicare program. The final data for FY 2002 showed a payment rate for intermediaries of 99.7 percent and 99.5 percent for carriers.

Coordination: The CMS is committed to being a reliable business partner for the provider community. The CMS works closely with its contractors to ensure that payment timeliness requirements are met.

Data Source(s): The primary data source is the Contractor Reporting of Operational and Workload Data (CROWD) system. CROWD contains contractor-specific bills/claims processing timeliness rates. Success in achieving the desired target will be measured at the national level.

MEDICARE OPERATIONS

Verification and Validation: The CMS routinely utilizes Contractor Performance Evaluation (CPE) for determining claims processing timeliness. Through CPE, CMS measures and evaluates Medicare contractor performance to determine compliance with specific responsibilities defined in the contract with CMS, and also responsibilities outlined in Medicare law, regulations, and instructions.

MEDICARE OPERATIONS

Performance Goal MO3-04**Increase the Use of Electronic Commerce/Standards in Medicare**

Baseline: In the baseline year FY 1999, intermediaries and carriers, respectively, reached Electronic Media Claim (EMC) rates of 97.1 percent and 80.9 percent.
FY 2004 Target: The FY 2004 target EMC rates will remain at 97 percent and 80 percent for intermediaries and carriers, respectively.
FY 2003 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. We anticipate that EMC levels will not rise until after FY 2005*, when initial Health Insurance Portability and Accountability Act (HIPAA) standards should have been implemented throughout the industry. (b) Complete baseline data for electronic claims status, electronic eligibility queries, electronic remittance advice (ERA), electronic funds transfer (EFT), and coordination of benefits (COB) transactions. (c) Complete implementation and testing of the HIPAA electronic transaction standards for: claims status and response, eligibility inquiry and response, prior authorization, and retail drugs claims, payments and inquiries. (d) Begin implementation of the HIPAA transaction standard for attachments. *Delayed from FY 2004
FY 2002 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. We anticipate that EMC levels will not rise until after FY 2005* when Health Insurance Portability and Accountability Act (HIPAA) standards are implemented throughout the industry, and the resulting issues have been satisfactorily resolved. (b) Complete implementation and testing, at Medicare contractor sites of the HIPAA Electronic Data Interchange (EDI) standards for the following Medicare transactions: electronic claims and COB, and the ERA. Begin implementation activities for the eligibility inquiries and response, and claims status inquiry and response transactions. *Delayed from FY 2003 Performance: Goal Met
FY 2001 Target: (a) Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers. (b) In the third quarter of FY 2001 begin to establish baseline data for electronic claims status, electronic eligibility inquiries, Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) transactions. (c) Begin implementation and testing, at Medicare contractor sites, the HIPAA EDI standards for the following Medicare transactions: electronic claims and coordination of benefits, ERA, eligibility inquiries and response, and claims status inquiry and response. Performance: Goal Partially Met
FY 2000 Target: Maintain EMC level of 97 percent for intermediaries and 80 percent for carriers through FY 2000. Performance: Goal Met

Discussion: The objective of this performance goal is to maintain, and, in the long-run, increase the percentage of activities accomplished electronically, rather than on paper form, on the telephone, or through other manual means. Increasing standardization and increasing the percentage of transactions performed electronically will increase the efficiency of the Medicare contractors and save Medicare administrative dollars.

HIPAA requires that the Secretary of HHS adopt, at a minimum, standardized electronic formats and data contents for claims, COB, ERA, claims status inquiry/response, eligibility inquiry/response, prior authorization, retail drugs processing, and attachments

MEDICARE OPERATIONS

for use by the entire U.S. health care payment industry. The Secretary is encouraged to adopt further standards as warranted, and is also required to periodically adopt updates to or replacements for the previously published standards. As a result, HIPAA transaction standards implementation and maintenance will be an ongoing project for Medicare.

Within two years of publication of the final rule for each standard, health care plans and providers of service that engage in electronic health care commerce are required to utilize the standards required under HIPAA (small plans have three years), and are prohibited from use of similar but non-compliant EDI transaction formats. The initial HIPAA transactions final rule was published in August 2000, but most Medicare contractor implementation activities could not begin until FY 2002 due to the need to assign available contractor programming hours and funds to projects determined to be a higher priority. This led to the deferral of a number of HIPAA implementation activities from FY 2001 to FY 2002 or FY 2003. This has been further delayed due to the passing of Public Law 107-105 in December 2001. The Administrative Simplification Compliance Act (ASCA) has given covered entities the option to obtain an extension for compliance to October 16, 2003 from October 16, 2002, giving the Medicare program an additional year to become HIPAA compliant. Medicare has filed for an extension as required under ASCA.

Over the last decade, CMS has placed a great emphasis on the use of electronic claims transmissions. The final data for FY 2002 showed an electronic claims submission rate of 98 percent for intermediaries and 83.7 percent for carriers. These rates are at or near a natural saturation point. We believe maintenance of EMC will be challenging in FY 2003 and FY 2004 given the HIPAA pre-implementation environment across the health care industry. However, the requirement for electronic claim submission under ASCA will help in maintaining and eventually increase the high level of EMC reached in previous years.

As Medicare providers begin to focus on the standards under HIPAA, we believe they will slow their EDI investments as they prepare for the new standards. This could result in at best, no increase in use of electronic transactions during the transition period to full use of the HIPAA standards. At worst, this could result in a temporary reduction of provider use of EDI if they wait for the industry to complete HIPAA implementation and work out any resulting problems. It is not realistic to expect any increase in provider EDI use during this transaction flux.

Our approach, therefore, has been to set targets on maintenance of electronic claims levels during this transition, implementation and testing of HIPAA standards, development of baseline measurements for other EDI transactions, and establishment of targets for these transactions. The target of establishing baseline data for electronic claim status, electronic eligibility inquiries, Electronic Remittance Advice and Electronic Funds Transfer in the third quarter of FY 2001 and in FY 2002 was delayed due to lack of funding. Collection of baseline data for carriers will begin April 1, 2003. Intermediary collection still needs to be scheduled.

MEDICARE OPERATIONS

Coordination: The CMS works closely with Medicare contractors in the development of EMC payment rates, and with Medicare contractors and Standard Developing Organizations (e.g., X12) in developing HIPAA standards.

Data Source(s): The data source for tracking EMC is CMS's Contractor Reporting of Operational and Workload Data (CROWD) system. Medicare contractors have started to separately report to CMS on status of HIPAA standards implementation and testing in FY 2002. In FY 2003, performance statistics should begin to be collected through the CROWD system for EDI transactions in addition to claims, if funding is available.

Verification and Validation: The CMS routinely utilizes the Contractor Performance Evaluation (CPE) for evaluating the accuracy of contractor data reporting, including CROWD. The CPE measures and evaluates contractor performance to determine if contractors meet specific responsibilities defined in the contract between CMS and the contractor, and also responsibilities outlined in Medicare law, regulations, and instructions. In addition, CMS has contracted with an IV & V company to conduct HIPAA-specific evaluations to validate Medicare contractor compliance with the adopted EDI standards. These verification and validation activities should be in effect through FY 2002, and will end in early FY 2003.

 MEDICARE OPERATIONS

Performance Goal MO4-04**Maintain CMS's Improved Rating on Financial Statements**

Baseline: In the FY 1998 financial statements, one item totaling \$3.6 billion was questioned by the auditors, resulting in a qualified opinion.
FY 2004 Target: Maintain a "clean" unqualified opinion on CMS's FY 2004 financial statements.
FY 2003 Target: Maintain a "clean" unqualified opinion on CMS's FY 2003 financial statements.
FY 2002 Target: Maintain a "clean" unqualified opinion on CMS's FY 2002 financial statements.
Performance: Goal met.
FY 2001 Target: Maintain a "clean" unqualified opinion on CMS's FY 2001 financial statements.
Performance: Goal met.
FY 2000 Target: Maintain a "clean" unqualified opinion on CMS's FY 2000 financial statements.
Performance: Goal met.
FY 1999 Target: Achieve a "clean" unqualified opinion on CMS's FY 1999 financial statements.
Performance: Goal met.

Discussion: Our goal is to maintain an unqualified opinion, which indicates that our financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources, and financing of CMS. Auditors review the financial operations, internal controls, and compliance with laws and regulations at CMS and its Medicare contractors.

Since FY 1998, we have made significant improvements on our financial statements. On the FY 1998 statements, we obtained a qualified opinion because the auditors found deficiencies in several aspects of the Medicare contractors' accounts receivable:

- (1) inadequate supporting documents to validate accounts receivable balances, and
- (2) inability to reconcile subsidiary financial records to the accounting reports submitted to CMS.

In FYs 1999, 2000, 2001, and 2002, CMS received unqualified audit opinions. During FY 2002, we tested financial management internal controls and reviewed accounts receivable balances at 15 Medicare contractors using Certified Public Accounting (CPA) firms. In addition, we created workgroups comprised of Central Office (CO) and Regional Office (RO) consortia staff responsible for addressing four key areas identified by auditors: follow up on corrective action plans (CAPs), reconciliations of funds expended to paid claims, trend analysis, and internal controls. The objectives of each workgroup are to clearly define CO and RO roles and responsibilities, as well as develop the national strategic plans to strengthen our Medicare contractor financial management oversight in these areas. Our long-term plan is to implement an integrated general ledger accounting system.

MEDICARE OPERATIONS

Coordination: This goal requires coordination with the Office of Inspector General (OIG), CMS internal financial components, CMS regional offices, Medicare contractors, and Medicaid State Agencies.

Data Source(s): The audit report of CMS's financial statements is issued by a CPA firm with oversight by the OIG.

Verification and Validation: The CMS works closely with the OIG and CPA firms during the audit and has the opportunity to review, discuss, and/or clarify the "Findings and Conclusions" presented. The General Accounting Office (GAO) has responsibility for the opinion on the consolidated government-wide financial statements, which includes oversight for the audit of the Department of Health and Human Services, of which CMS's outlays are approximately 83 percent.

 MEDICARE OPERATIONS

Performance Goal MO5-04

Improve CMS Oversight of Medicare Fee-for-Service Contractors

Baseline: Developmental. There was extensive variation in the format of reports and review protocols and timeliness of report submission during the period from FY 1995 to FY 1998.
FY 2004 Target: Developmental.
FY 2003 Target: Building on program achievement in prior years, CMS will move still further toward its goal of national uniform contractor evaluation.
FY 2002 Target: Building on experience of FY 2001 and continuing towards goal of national uniform contractor evaluation.
Performance: Goal Met
FY 2001 Target: Building on progress achieved in FY 1999 and FY 2000, CMS will move further toward its goal of national, uniform contractor evaluation.
Performance: Goal Met

Discussion: In FY 2001, Medicare fee-for-service payment contractors received approximately \$1.45 billion in program management and Medicare Integrity Program funding to process nearly 931 million claims and administer benefit outlays of approximately \$197 billion. In FY 2003, they will process an estimated 1 billion Medicare claims; handle more than 7 million appeals; respond to over 40 million inquiries from providers and beneficiaries; enroll, educate, and train providers and suppliers; educate and assist beneficiaries; and perform other responsibilities on behalf of CMS.

In FY 1995, CMS decentralized its approach to evaluating these contractors and afforded considerable flexibility to CMS regional offices in planning and conducting evaluations of contractors within each region. Decentralization of these reviews produced inconsistency from region to region, and difficulty in assessing national contractor performance.

Beginning in FY 1999 and continuing in FY 2000 and FY 2001, CMS focused on contractor performance evaluation (CPE) through a risk-based, consistent national approach to contractor review that allocates resources to evaluating high-risk contractors and/or program benefits. The criteria for selecting additional contractors for more intensive review include: claims volume, administrative costs, benefit payout, integrity issues and past performance.

In 2001, all onsite reviews were conducted by national teams using standardized review protocols, under the guidance of the same project leaders assigned to each business function. There were 171 onsite regional office/central office (RO/CO) and multi-regional team reviews completed in 15 business functions. There were 600 additional desk reviews completed using contractor operational data. Greater review consistency was achieved through the increased use of national (RO/CO) review teams trained to evaluate functions performed by these high-risk contractors. Several contractor activities, such as accounts receivable, computer systems security, and the effectiveness

MEDICARE OPERATIONS

of contractor financial internal controls, were evaluated through contracts with consulting or accounting firms, which used a standard review program.

In 2002, national (RO/CO) teams conducted evaluations using standardized protocols on which they had received training. Project Leaders, each assigned to a single business function, provided guidance to the teams evaluating the function and were responsible for approving the final evaluation reports issued to contractors. A total of 132 RO/CO teams conducted onsite reviews in 13 different business functions. Nearly 500 additional desk reviews, conducted by reviewing contractor operational data, were also performed.

We are achieving greater review consistency through the increased use of national (RO/CO) review teams trained to evaluate functions performed by the Medicare contractors. Additional steps have been taken to foster greater consistency including: standardizing review protocols, national training on the protocols, training by USDA's Government Audit Training Institute on approaches to performance audits, standardizing CPE review reports and management reports, performing a quality review in central office of each report concurrent with the Project Leader's review of the draft, and reviewing evaluators' work papers for a limited number of reviews in each business function. Finally, through contracts with consulting or accounting firms, some contractor activities such as accounts receivable and the effectiveness of contractor financial internal controls were evaluated through reviews conducted by consulting CPA firms.

Coordination: CPE coordinates closely with management and staff from CMS's central and regional offices. Working with the regions, CO managers with responsibility for the various business functions set annual evaluation priorities and develop standard review protocols utilized by the review teams. These same CO components name technical assistants who help by training the reviewers on the evaluation protocols and provide any needed technical guidance throughout the evaluation period. In the future, we will coordinate still further within CMS, which plans to use contracted SAS-70 reviews.

Data Source(s): Data on the extent of use of contractor review teams and the timeliness of issuance of each Report of Contractor Performance will be available through internal management reporting.

Verification and Validation: The CMS staff will review the reports cited under data sources to assess performance and report on progress.

MEDICARE OPERATIONS

Performance Goal MO6-04**Increase Referral of Eligible Delinquent Debt for Cross Servicing**

Baseline: Prior to FY 2001, CMS referred over \$2 billion in eligible delinquent debt for cross servicing. This is approximately 25 percent of CMS's eligible delinquent debt.
FY 2004 Target: Continue to refer 100 percent of eligible delinquent CMS receivables to Treasury. Improve the procedures for identifying, monitoring and tracking these debts.
FY 2003 Target: Continue to refer 100 percent of eligible delinquent CMS receivables to Treasury. Improve the procedures for identifying, monitoring and tracking these debts.
FY 2002 Target: Increase the dollar amount of debt referred for cross servicing to 100 percent of eligible delinquent debt.
Performance: Goal not met. Due to various manual processes used to track and report Medicare debt, the referral process was more time consuming and labor intensive than originally anticipated. The CMS referred approximately 90 percent of its eligible delinquent debt by the end of the fiscal year. The balance of eligible debt will be referred in FY 2003.

Discussion: The Debt Collection Improvement Act of 1996 (DCIA) is intended to facilitate collections by the Federal Government and to encourage the streamlining of procedures and coordination of information within and among Federal agencies. The DCIA mandates Federal agencies to refer eligible delinquent debt (180 days past due) to the Department of Treasury or a Treasury designated Debt Collection Center (DCC) for cross servicing. Debts not eligible for referral include debts: (1) in bankruptcy status, (2) with an appeal pending at any level; (3) in active litigation, or (4) where the debtor is deceased.

Prior to FY 2002, CMS referred approximately \$4 billion in delinquent debt to Treasury for cross servicing and offset. By the end of FY 2002, CMS's original goal was to refer 100 percent of eligible delinquent debt. The CMS is working hard in order to meet its goal of referring 100 percent of all eligible delinquent debt. The debt referral process has become more labor intensive than we originally projected based on our pilot implementation efforts. This is because our remaining unrefereed debt contains numerous debts of relatively small amounts. This debt is primarily made up of beneficiary and Medicare Secondary Payer debt. As of the end of FY 2002, CMS referred approximately 90 percent of eligible delinquent debt. The remaining debt will be referred in fiscal year 2003.

The CMS initially targeted only Medicare Part A and Part B overpayments for referral for cross servicing. However to meet our goal to refer 100 percent of eligible delinquent debt, CMS revised its debt referral procedures to utilize resources at the Medicare Contractor and Regional Office locations. These referral procedures include identifying debt eligible for referral, verifying the status and balance of the debt, certifying that the debt is valid and legally enforceable, sending a notice which appraises the debtors of their rights, and notifying the debtor of the intent to refer the debt for cross servicing.

MEDICARE OPERATIONS

Medicare Secondary Payer (MSP) debt, which is a large percentage of CMS's delinquent debt, was added to the referral process in FY 2001. In FY 2002, CMS began to focus on other types of debts in its accounts receivable balance, many of which reside in various databases internal to CMS.

Coordination: The CMS and the Medicare Payment Contractors, the Regional Offices and various Central Office components maintain ongoing coordination to monitor and track the debts selected for referral, debts referred, and collections received as a result of referrals. Referral efforts are coordinated with the Department of Treasury and the Program Support Center (PSC) of the Department of Health and Human Services.

Data Sources: The CMS tracks its non-MSP overpayments through the Provider Overpayment Reporting (POR) system, the Physician/Supplier Overpayment Reporting (PSOR) system, and Medicare Contractor internal systems. MSP debt information is housed in the Medicare contractor locations. Central Office debt resides on various databases and is also contained in the R321 report. Medicare contractors and CMS enter debt information into the Debt Collection System (DCS) prior to referral.

The CMS Healthcare Integrated General Ledger Accounting System (HIGLAS), which will include an accounts receivable system, is in the pilot design, development and implementation phase. This is an 18 month phase. Once implemented HIGLAS will interface with Medicare Contractor selected systems and will further streamline the current debt referral process. The implementation of this new system is expected to be completed in FY 2006.

Other types of accounts receivable, which are not housed in CMS contractor's systems, are being identified and tracked for referral to cross servicing.

Verification and Validation: Data systems outlined above will be used to track and monitor progress. At this time, the present system has limited edits to ensure data integrity. Until an integrated system is developed and implemented, CMS will monitor the data in the various systems used to ensure data integrity and consistency. The CMS will verify that the information in the DCS system is consistent with the data reported in the POR/PSOR systems. Contractor data will be verified using the Contractor Financial Reports, Statement of Financial Position (HCFA Form 750) and Status of Accounts Receivable (HCFA Form 751). In addition, CMS will request reports from the PSC on the status of debt that was referred to Treasury and other debt.

MEDICARE OPERATIONS

Performance Goal MO7-02

**Improve Effectiveness of Dissemination
of Medicare Information to Beneficiaries in Fee-for-Service
(Discontinued after FY 2002)**

Baseline: In FY 1997, beneficiaries received various notices indicating claims activity for most Part A and Part B services.
FY 2002: The CMS plans to complete national implementation of the Medicare Summary Notice (MSN).
Performance: National MSN implementation has been completed. Goal met.
FY 2001: Same as FY 2000. (To better reflect budget linkage, this goal was moved from the Medicare+Choice User Fee budget category.)
Performance: Carrier/FI implementation at 81 percent and contractor support ongoing. Goal met.
FY 2000: Support MSN efforts, aiming toward full implementation in FY 2002.
Performance: Carrier/FI implementation at 81 percent. Goal met.

Discussion: To enhance beneficiary understanding of their Medicare benefits and reduce confusion over what Medicare covered for their services, CMS is continuing and, in FY 2002, completing its nationwide implementation of the MSN. The MSN combines information sent to Medicare beneficiaries on benefits received under Medicare Part A and Part B into easy-to-read monthly statements.

The MSN reduces beneficiary confusion and paperwork by providing a monthly summary of services delivered under Part A, and separate summaries for services under Part B, and durable medical equipment--like monthly credit card statements. The MSN also reduces confusion by providing claim information in a consistent format that is clearer, more concise, and easier to understand than current notices. MSN pilot test results show that beneficiaries can better understand what Medicare paid or denied and what they may owe. The MSN also contains important information regarding Medicare fraud and abuse detection, including new "Help Stop Fraud" messages to help beneficiaries identify potential fraud.

In FY 2002, we modified the Part A MSN format to incorporate the Balanced Budget Act (BBA) requirement to list the amount Medicare paid to the provider (already included in the Part B MSN). Modifications to the existing beneficiary/provider outreach and education materials will be made as a result of these changes to the MSN. The CMS has completed national MSN implementation.

Coordination: Teleconferences between CMS and fiscal intermediaries, carriers, and standard system representatives will play a critical role as CMS grows closer to national implementation of the MSN. Feedback on the MSN comes from a variety of organizations, including beneficiary advocacy groups; Medicare Quality Improvement

MEDICARE OPERATIONS

Organizations; State Health Insurance Assistance Programs; and Beneficiary Advisory Councils.

Data Source(s): Successful completion of the MSN will rely on the Medicare Part A, Part B, and Durable Medical Equipment Regional Carrier (DMERC) contractor systems.

Verification and Validation: The CMS oversees the performance of contractors through routinely scheduled site visits and performance reviews.

MEDICARE OPERATIONS

Performance Goal MO8-04**Improve Effectiveness of Dissemination of
Medicare Information to Beneficiaries**

Baseline: (1) In 1999, 67 percent of beneficiaries who sought Medicare information from Medicare sources reported that the information they received answered their question(s). (2) In 1999, 47 percent of beneficiaries knew that most people covered by Medicare could select from among different health plan options within Medicare.
FY 2004: Achieve (1) 77 percent of beneficiaries who reported the information they received answered their question(s), and (2) 57 percent of beneficiaries who knew that most people covered by Medicare can select from among different health plan options within Medicare.
FY 2003: Same as FY 2002/2001.
FY 2002: Same as FY 2001.
Performance: Goal met. Data being collected and monitored.
FY 2001: Continue collecting and monitoring Medicare Current Beneficiary Survey (MCBS) data for final reporting in FY 2004. Performance: MCBS data being collected for the 5-year period. We are on track toward meeting the goal by FY 2004.
FY 2000: By 2004, (1) 77 percent of beneficiaries will report that the information they received answered their question(s), and (2) 57 percent will know that most people covered by Medicare can select from among different health plan options within Medicare. Performance: MCBS data being collected for the 5-year period. We are on track toward meeting the goal by FY 2004.

Discussion: The Balanced Budget Act (BBA) of 1997 mandated the greatest changes to Medicare since its inception. One of these changes was the expansion of health insurance options under Medicare+Choice. In order to help beneficiaries make informed health care decisions, CMS employs a variety of strategies through many CMS beneficiary-centered programs to maximize information channels and to ensure that targeted audiences, are reached with the “right information at the right time.”

The National *Medicare & You* Education Program (NMEP) is an example of one beneficiary-centered program that strives to provide information through a variety of channels in order to educate beneficiaries and help them make more informed decisions concerning: Medicare program benefits; health plan choices; supplemental health insurance; rights, responsibilities and protections; and health behaviors. The primary objectives of the education efforts are to ensure that beneficiaries receive accurate, reliable information; have the ability to access information when they need it; understand the information needed to make informed choices; and perceive the NMEP (and the Federal Government and its private sector partners) as trusted and credible sources of information. The NMEP, along with other national and local programs strive to raise beneficiary awareness from different perspectives; e.g., through public nursing home

MEDICARE OPERATIONS

campaigns through the Quality Improvement Organizations. All programs are evaluated and assessed to determine their effectiveness and to implement further improvements.

In developing our targets, we assumed an average 2 percentage point increase per year; thus, 10 percentage points over the 5-year period. We figured that this was achievable given the emphasis on the education program. The targets are set for FY 2004, in order for the percentage increases to be large enough to be statistically detected.

Coordination: The CMS is continuing the process of building alliances with other consumer centered organizations to improve the dissemination of information to educate Medicare beneficiaries and those that act on their behalf. These organizations have the ability to assist us in the development and dissemination of Medicare information on a much broader basis at regional and local levels.

Data Source(s): The primary source of data on beneficiary understanding of Medicare will be the MCBS. The MCBS is an on-going personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage. Over a 5-year period, CMS will track changes in the ability to access information and beneficiary awareness.

Verification and Validation: The MCBS is subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device.

MEDICARE OPERATIONS

Performance Goal MO9-04**Improve Beneficiary Understanding of Basic Features of the Medicare Program**

Baselines: (1) Fifty-three percent of Medicare beneficiaries were aware that Medicare has a 1-800-MEDICARE toll-free number. (2) Beneficiaries were able to answer correctly 2.75 questions out of 6 questions measuring beneficiary understanding of different components of the Medicare program.
FY 2004 Targets: (1) Sixty-five percent of Medicare beneficiaries are aware that Medicare has a 1-800 number. (2) Beneficiaries are able to answer correctly 3.50 questions out of 6 questions measuring beneficiary understanding of different components of the Medicare program.
FY 2003 Target: Continue collecting and monitoring the Medicare Current Beneficiary survey (MCBS) data for reporting on CY 2004 data.
FY 2002 Target: Developmental. Baselines and future targets will be developed. Performance: Goal met. Baselines and targets developed.
FY 2001 Target: Complete all actions necessary to implement a measurement and reporting system, including: (1) developing a list of core features of Medicare that beneficiaries need to know in order to use the program effectively; (2) obtaining input on the list from relevant advisory bodies; (3) designing and testing survey questions to capture the extent to which beneficiaries are aware of the basic features on the list; (4) integrating the questions into existing MCBS computer assisted personal interviewing systems; (5) fielding the questions in the spring/summer 2001 round of the MCBS. Performance: Goal met. Steps 1-5 completed. Survey fielded.

Discussion:

The purpose of this performance goal is not to turn every beneficiary into an expert on Medicare; consumer research has shown that beneficiaries generally seek information about the program only as specific needs arise. Our objectives in this goal are:

- to improve awareness of the core features of Medicare that beneficiaries need to know to use the program effectively, and
- to improve beneficiary awareness of CMS sources from which additional information can be obtained if needed.

As part of this goal, there are two measures. The first measure is the number of questions answered correctly out of six questions on a knowledge quiz. The quiz includes the following true/false questions:

- (1) Most people covered by Medicare can select among different kinds of health plan options;
- (2) Medicare without a supplemental insurance policy pays for all of your healthcare expenses;
- (3) People can report complaints to Medicare about their Medicare managed care plans (HMOs) or supplemental plans if they are not satisfied with them;

 MEDICARE OPERATIONS

- (4) If someone joins a Medicare managed care plan (HMO) that covers people on Medicare, they have limited choices about what doctors they can see;
- (5) If someone joins a Medicare managed care plan (HMO) that covers people on Medicare, they can change or drop the plan and still be covered by Medicare; and
- (6) Medicare managed care plans (HMOs) that cover people on Medicare often cover more health services, like prescribed medicines, than Medicare without a supplemental policy.

The second measure is how many beneficiaries are aware of the CMS 1-800 MEDICARE toll-free number.

The CMS employs a variety of strategies to ensure that targeted audiences are reached with “the right information at the right time” to make informed health care decisions in order to accomplish these objectives. Ongoing formative research and consumer testing is conducted as part of all programs to ensure the development of products and information that will be understandable and delivered through the most appropriate, maximum number of information channels to reach the broadest audiences. These audiences include vulnerable populations who have problems with access to information. The CMS works across the organization to ensure maximum and efficient use of existing infrastructures to carry key Medicare messages and information to beneficiaries; e.g., expanding an existing information channel to provide new information to beneficiaries rather than building a new infrastructure. The CMS has begun to promote and publicize information channels and resources for many of our programs to further raise the awareness levels of Medicare beneficiaries.

The CMS’s National *Medicare & You* Education Program (NMEP) is an example of one beneficiary-centered program that strives to provide information to improve awareness of Medicare core features and sources. This program uses a variety of information channels to raise awareness including a handbook in print, toll-free telephone services through 1-800-MEDICARE, information via www.medicare.gov, and direct counseling support through the State Health Insurance & Assistance Program. NMEP along with other national and local programs strive to raise beneficiary awareness from different perspectives; e.g., public nursing home campaigns through the Quality Improvement Organizations. All programs are evaluated and assessed to determine their effectiveness and to implement further improvements.

Coordination: All CMS beneficiary-centered programs emphasize partnerships with Federal, State, local agencies, and beneficiary advocacy groups. These organizations have the ability to assist us in the development and dissemination of Medicare information on a much broader basis at regional and local levels. As an example, CMS has built an alliance network of over 120 national organizations and has formed a National Advisory Panel on Medicare Education that consists of national experts in consumer education. This panel advises the CMS Administrator on ways to enhance our efforts in consumer awareness on Medicare.

MEDICARE OPERATIONS

Data Source(s): The primary source of data on beneficiary understanding of Medicare will be the MCBS. The MCBS is an ongoing personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage. The MCBS included questions asking beneficiaries about their awareness of basic features of the Medicare program.

Questions were in a "true," "false," or "not sure" format. For ethical reasons, after asking questions, MCBS interviewers made the correct answers to the questions available to the respondents (beneficiaries cannot inadvertently be left with any misperceptions about the program). Therefore, the act of surveying these respondents would confound subsequent measurement of their awareness of the program features. Sampled beneficiaries remain in the MCBS for 3 years and then rotate out of the survey. Thus, each year about one-third of the overall MCBS sample is new and two-thirds are returning. To avoid instrumentation bias, the questions will only be asked of new MCBS members. This new part of the MCBS sample is itself nationally representative of the Medicare population.

Verification and Validation: The MCBS is subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device. All data from the MCBS are carefully edited and cleaned prior to the creation of analytic data files. Sample weights will be prepared that allow adjustments to survey estimates to account for differential probabilities of selection in the MCBS sample, under-coverage, and differential patterns of survey non-response. Statistical precision will be calculated and presented with the estimates.

FEDERAL ADMINISTRATIVE COSTS

Federal Administrative Costs

Federal Administrative Costs	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget*	FY 2004 Estimate
Total Budget Authority	\$504.7 M	\$530.5 M	\$562.5 M	\$580.6 M
Full-Time Equivalents	4,610	4,632	4,661	4,486**

Funding for Federal Administrative Costs provides roughly 4,486** CMS employees the ability to execute the Government's responsibilities in continuing Medicare and Medicaid services. These responsibilities include providing direct program services to beneficiaries, providers, Medicare contractors, and State agencies, as well as the general public. In addition, these responsibilities include combating fraud, waste, and abuse; overseeing safety and quality of health care; promoting managed care; responding to data requests; implementing legislation; and developing efficient payment and operating systems.

* This column reflects the current estimate for FY 2003. Budget authority in the FY 2003 President's budget was \$587.2 million.

** Includes 78 Full Time Equivalents (FTEs) funded by non-appropriated funds, and 10 FTEs funded through the Medicare Operations line item.

In addition to the fact that Federal Administrative Costs provide the "backbone" for most of the GPRA goals, other representative goals related to this budget category but not listed in the chart are:

- Improve Medicare Managed Care Plans' Administration of Appeal Process (MB4-04)
- Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements (MO2-04)
- Increase the Use of Electronic Commerce in Medicare (MO3-04)
- Maintain CMS's Improved Rating on Financial Statements (MO4-04)
- Improve CMS's Oversight of Contractors (MO5-04)
- Increase Referral of Eligible Delinquent Debt for Cross Servicing (MO6-04)
- Improve the Management of the Survey and Certification Budget Development and Execution Process (QSC3-04)
- Improve CMS's Information Systems Security (RP1-04)

FEDERAL ADMINISTRATIVE COSTS

Performance Goals	Targets	Actual Performance	Ref.
Develop and Implement an Information Technology Architecture	FY 04: --Continue maturing the ITA --Begin implementation of architectural support services --Implement IT policies and procedure development, as needed FY 03: --Continue maturing the ITA --Develop architectural support services --Implement IT policies and procedures and continue adding as needed FY 02: --Continue policy and procedure development --Complete development of System Design Reference Models & integration into SDLC activities -- Monitor ITA (Enterprise Architecture) conformance as part of Investment Process FY 01: -- Develop template configuration for major system development -- Integrate ITA into investment review process FY 00: Approve standards and policies for basic services (target unchanged, language was modified)	FY 04: FY 03: FY 02: --Established IT policy and procedure development teams. Developed and promulgated 2 policies, 15 remaining policies being drafted (Goal met) -- Development of all (8 in total) SDRMs completed 2/13/02 & projects have begun using the SDRMs in their SDLC activities. (Goal met) -- Monitoring Enterprise Architecture conformance as part of the IT Investment Management Review Process. Established baseline Products and Standards Profile. (Goal met) FY 01: -- Being developed; Completion of 6 templates expected 3/1/02 (Goal not met) --Integrated (Goal met) FY 00: All standards approved (Goal met)	FAC2 See FY 03 Revised Final
Improve CMS's Information Systems Security	See Revitalization Plan budget category		

FEDERAL ADMINISTRATIVE COSTS

Performance Goals	Targets	Actual Performance	Ref.
Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice:	FY 04: -- Implement PPS system for Inpatient Psychiatric Hospital services -- Implement revised risk-adjusted payments for Managed Care FY 03: -- Continue design of PPS system for Inpatient Psychiatric Hospital services -- Begin combined collection of data for risk adjusted payments for Managed Care FY02: -- Implement Inpatient Rehabilitation Facilities PPS -- Improved risk-adjustment model for Medicare+Choice FY 01: -- Implement Home Health Agency PPS -- Make risk-adjusted payments based on PIP-DCG model FY 00: -- Implement Hospital Outpatient PPS -- Publish final HHA PPS Regulation -- Make Risk-adjusted payments FY 99: -- Establish SNF PPS -- Make Risk Adjusted payments	FY 04: FY 03: FY 02: -- IRF PPS rule published 8/7/01. Implemented 1/1/02 (Goal met) -- Inpatient/ambulatory risk-adjustment model selected (Goal met) FY 01: -- HHA PPS implemented 10/1/00 (Goal met) -- (Goal met) FY 00: -- Outpatient PPS implemented 8/1/00 (Goal met) -- Rule published 7/3/00 (Goal met) -- Risk adjusted payments began 1/1/2000 (Goal met) FY 99: -- (Goal met) -- (Goal met) Baseline: Cost reimbursement for HHA, SNF, inpatient rehab, outpatient hospital and psychiatric hospitals. Payments to managed care plans not risk-adjusted.	FAC4 

FEDERAL ADMINISTRATIVE COSTS

Performance Goals	Targets	Actual Performance	Ref.
Improve CMS's Workforce Planning	FY 04: Update workforce planning data and establish a knowledge and skill level baseline FY 03: Complete development of and implement automated workforce planning modules FY 02: Build and populate an automated workforce planning system based on work roles. - Develop work roles (i.e., groupings of positions with similar functions and skill requirements), and assign each CMS position to a work role. - Determine future skill and knowledge requirements.	FY 04: FY 03: FY 02: Developed work roles and assigned CMS positions to work roles. Determined future skills and knowledge requirements. (Goal met) (NEW DATA)	FAC6 See FY 03 Revised Final 8 
Improve CMS's Management Structure	FY 04: Establish a baseline using data from the automated management competency system. FY 03: (a) Implementation of a competency-based performance management (planning and appraisal) program for managers; (b) Implementation of an awards and recognition program for managers; and (c) Exploration of data sources	FY 04: FY 03:	FAC7 See FY 03 Revised Final 8 
Strengthen and Maintain Diversity at all Levels of CMS	FY 04: Same as FY 2003 FY 03: Increase representation of EEO groups in areas where they demonstrate underrepresentation	FY 03: FY 02: Progress made FY 01: Progress made FY 00: EEO groups representing manifest imbalances in CMS workforce (Baseline)	FAC8 8 
Increase awareness about the opportunity to enroll in the Medicare Savings Programs	FY 04: Increase awareness of Medicare Savings Programs to 14% FY 03: Increase awareness of Medicare Savings Programs to 13% FY 02: Develop baseline and set future targets	FY 04: FY 03: FY 02: 11% (Goal met) (Baseline)	FAC9 3

FEDERAL ADMINISTRATIVE COSTS

Performance Goals	Targets	Actual Performance	Ref.
Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization	FY 04: Developmental FY 03: -- Achieve greater administrative efficiency through consolidation of administrative functions and reduction of FTEs by 93 FTE's -- Achieve a more citizen-centered focus through organizational layering to 4 layers	FY 04: FY 03: FY 02: --4632 FTE Ceiling (Baseline 1/1/02) --5 layers (Baseline 1/1/02)	FAC10 

Performance Results Discussion

The CMS's Federal Administrative Budget funds a wide range of activities. Five key areas that fall under this category are: implementing the provisions of the Balanced Budget Act (BBA) of 1997 and the Health Insurance Portability and Accountability Act (HIPAA); modernizing and strengthening CMS's information technology (IT) systems; improving systems security and workforce planning.

The provisions of the BBA, Balanced Budget Refinement Act (BBRA), and HIPAA made significant changes in CMS's programs. These changes were the largest the agency has seen since its inception. Two goals that support these provisions are to develop new Medicare payment systems and to ensure compliance with HIPAA.

Medicare Payment Systems – The goal to develop new payment systems in fee-for-service and Medicare+Choice measures our progress towards implementing prospective payment systems (PPS) for skilled nursing facilities, home health agencies, hospital outpatient departments, inpatient rehabilitation facilities and psychiatric hospitals. Prospective payment for these services is expected to result in more efficient provision of care and lower costs to the Medicare program.

In FY 1998, CMS began implementing a PPS for skilled nursing facilities. In FY 2000 a PPS was implemented for hospital outpatient departments. On October 1, 2000, CMS implemented a PPS for home health and we implemented PPS for inpatient rehabilitation facilities in FY 2002. Additionally, CMS will begin developing a psychiatric hospital PPS in FY 2002. Risk-adjusted payments for Medicare+Choice plans were implemented January 1, 2000 and we continue to improve the collection of data.

Information Technology Architecture (ITA) - The information technology architecture goal is designed to track the development and implementation of an IT architecture framework. We made substantial progress toward reaching our FY 2001 targets to integrate ITA requirements into our internal project review process and develop standard configuration templates. These goals were not fully met due to staffing and budget shortfalls. The ITA has been integrated into the IT Investment Management Review

FEDERAL ADMINISTRATIVE COSTS

process through CMS's Integrated IT Investment Management Roadmap effort. Architecture review checkpoints throughout the Roadmap are being used to ensure compliance with the ITA. The CIO Technical Advisory Board is performing this review role. A baseline IT products and standards profile has been established. We met our FY 2002 goals, as we, CMS, developed eight configuration templates (now being called "System Design Reference Models") for use in system development life cycle (SDLC) efforts. Projects have begun using the SDRM in their SDLC activities. The CMS is continuing architectural development through a segmented approach. One segment, Medicare fee-for-service claims processing, was completed in FY 2002. In addition, workgroups were established in FY 2002 to develop IT policies and procedures. Two policies were developed and promulgated. Policies in 15 remaining areas are being drafted.

Workforce Planning – To meet the rising challenge of maintaining a workforce with the specific skills necessary to accomplish our goals, and consistent with the President's Management priorities, CMS is instituting a systematic approach to assessing and addressing skills and knowledge needs. In FY 2000, CMS developed a competency catalogue of skills and knowledge required to accomplish Agency functions. This catalogue was used in FY 2001 to inventory current employee competencies.

Skill and knowledge gaps identified through this one-time data collection initiative were ranked by agency management, resulting in the identification of gaps in specific knowledge and skills. We met our FY 2002 target by developing a prototype system. Work roles were developed and assigned to all CMS positions, and future skill and knowledge requirements were determined. After evaluating the initial prototype, CMS decided to develop a series of automated workforce planning modules linked to our human resource information system, rather than build a "stand-alone" workforce planning system. Completion of these modules is expected in FY 2003. Full implementation, in FY 2004, will give CMS data on knowledge and skill gaps that can be tracked over time.

Management Structure – The CMS is developing a performance goal to improve our management structure. Through workforce planning, we have identified specific competency areas across the Agency that need to be targeted for improvement, including CMS's management and leadership. We will be focusing on activities such as recruitment and selection, performance management, awards and recognition, and continuous learning, to strengthen the leadership skills of our management.

In March of 2002, CMS fully implemented a competency-based recruitment and selection process. In FY 2003, we are developing an automated system (form and database) that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports. This information will allow us to measure the improvement in management competency as a result of CMS's Leadership and Management Development Strategy (LMDS) activities. We will gather baseline data from the automated system in FY 2004 to begin measuring improvement in the leadership competencies.

FEDERAL ADMINISTRATIVE COSTS

Workforce Diversity – We are pleased to report progress in our goal to increase representation in the CMS workforce of Equal Employment Opportunity (EEO) groups in areas where they demonstrate underrepresentation. In 2001, we realized increases for individuals with disabilities, American Indians/Alaskan Natives and Hispanics.

Official figures provided by the Department of Health and Human Services for the end of fiscal year 2002 indicate that CMS again realized an increase in the workforce representation of Hispanics, up from 3.7 percent in FY 2001 to 4.4 percent in FY 2002. In addition, during fiscal year 2002 CMS successfully increased representation of previously underrepresented EO groups within certain occupational series. Most notably, American Indian females in the 1801 Inspector General/Investigator series advanced from no representation to above parity with the civilian labor force (from 0 percent in FY 2001 to 0.78 percent in FY 2002). Representation for four other groups demonstrated improvement as well, moving out of manifest imbalance during the fiscal year: Hispanic males in the 0107 Health Insurance Specialist series (from 1.29 percent in FY 2001 to 1.33 percent in FY 2002); Asian American females in the 0301 Miscellaneous Administration/Program Administration series (from 0.46 percent in FY 2001 to 1.33 percent in FY 2002); Hispanic females in the 0334/2210 Computer Specialist series (from 1.06 in FY 2001 to 1.47 percent in FY 2002); and white females in the 0501 Financial Administration/Program Administration series (from 21.13 percent in FY 2001 to 27.12 percent in FY 2002).

We continue to utilize various initiatives and hiring authorities to address the underrepresentation of certain EEO groups at CMS. We also reference public sector and private industry reports to replicate successful practices of other Federal agencies in addressing EEO group underrepresentation.

Medicare Savings Programs – In the past CMS focused its efforts on increasing enrollment of dual eligible beneficiaries. Dual eligible beneficiaries are eligible for both the Medicare and the Medicaid programs. The goal to increase awareness about the opportunity to enroll in the Medicare Savings Programs will target the low-income Medicare beneficiary population. Initially this goal will focus on individuals who are eligible for the Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB) programs. CMS met our target for FY 2002 by establishing a baseline of 11 percent of Medicare beneficiaries that were aware of Medicare Savings Programs. Additionally, targets were established for subsequent years. In FY 2003 we have established a target to increase awareness to 13 percent and 14 percent in FY 2004.

Implement CMS Restructuring Plan – In support of the President's Management Agenda, we have made significant progress toward our FY 2003 goal to achieve greater administrative efficiency through consolidation of administrative functions and a reduction in staffing, and to achieve a more citizen-centered focus through organizational layering.

FEDERAL ADMINISTRATIVE COSTS

In support of our target to consolidate administrative functions, we awarded the Consolidated Information Technology Infrastructure Contract (CITIC) in May 2002 under which CMS has combined multiple information technology support contracts into a consolidated contract. In addition, we have made progress reducing our administrative FTEs using a combination of attrition and re-deployment of incumbents to non-administrative, citizen-centered service positions. We have also completed a reorganization of the human resources (HR) function to facilitate potential consolidation at the Department of Health and Human Services (HHS) level and/or cross servicing with other Operating Divisions within HHS. This reorganization aligned CMS HR functions with consolidation objectives. As of December 2002, 15 of the 16 CMS-identified vertical delayering action items (94 percent) have already been completed. We are confident our efforts will result in meeting our FY 2003 goal of greater administrative efficiency and achieving a more citizen-centered focus.

FEDERAL ADMINISTRATIVE COSTS

Performance Goal FAC2-04

Develop and Implement an Information Technology Architecture

Baseline: The CMS use of Information Technology (IT) could not adequately support the future business needs of the Agency. We determined that the development of an improved Information Technology Architecture (ITA) was needed.
FY 2004 Target: Continue maturing the ITA (Enterprise Architecture). Revise and update promulgated policies to ensure continued compliance with Federal and legislative requirements and to address lessons learned from implementation of these promulgated policies.
FY 2003 Target: Continue to develop the ITA (Enterprise Architecture), including further expansion of both breadth and depth using a segmented approach, with specific segments determined as opportunities and needs arise. Complete development and promulgation of remaining IT policies.
FY 2002 Target: Continue development of policies and procedures required for implementation of the HCFA ITA and migration strategy. Complete development and integrate use of standard configuration templates, a.k.a., "System Design Reference Models," with major system development life cycle activities. Monitor ITA conformance as part of the IT Investment Review Process. Performance: Goal Met
FY 2001 Target: Develop standard configuration templates for use in major system design efforts. Integrate the ITA conformance criteria into the IT Investment Review Process. Performance: Goal Partially Met -- First set of templates near completion, conformance criteria integrated into IT Investment Review Process.
FY 2000 Target: Approve standards and policies for each of the 66 basic service areas identified in the HCFA ITA technical reference model. Performance: Goal Met -- All basic service areas approved, policies addressed as needed.

Discussion: The CMS, as required by the Clinger-Cohen Act of 1996, is developing an integrated, enterprise-wide ITA that is aligned with CMS's strategic business objectives. The ITA will document the relationships between CMS's business and management processes and the technology that supports those processes. Its purpose is to ensure that IT requirements are aligned with the business processes that support CMS's mission and that a logically consistent set of policies and standards is developed to guide the engineering of CMS's IT systems. The CMS's Chief Information Officer (CIO) has overall responsibility for the ITA, and has appointed an architect to oversee its development and implementation.

The CMS has developed an IT vision on which the target ITA will be based. Key elements of this vision are:

- a central "core" of well-managed databases;
- modular applications systems accessing the databases; and
- structured interfaces to facilitate access to the data in the core databases.

The CMS has completed the preliminary target architecture and migration strategy. As CMS continues to implement and mature this architecture and migration strategy, the Agency will begin to replace current, system-specific databases with new databases that

FEDERAL ADMINISTRATIVE COSTS

have broad applicability across many systems. It will also redesign-antiquated data systems and technology to take advantage of modern, more flexible programming languages. The result will be a systems environment that is more responsive to current and future business demands, less expensive to maintain, and better able to support program operations and policy decision-making.

The CMS has developed an ITA metrics program to measure the implementation and effectiveness of the architecture. It includes two types of metrics: goal-based and process-based. The goal-based metrics relate to 1) ITA maturity; 2) awareness/compliance relative to the ITA; and 3) organizational impact of the ITA. Selected goal-based metrics will be used for GPRA reporting. The process-based metrics will be used by CMS for internal improvements to the ITA and related processes.

In FY 2002 CMS began its metrics program for GPRA reporting by measuring ITA maturity using the number of standards and preferred IT products that have been approved by the IT Council. Since a baseline of these standards and products has now been established, CMS believes that a sufficient level of ITA maturity relative to standards and products has been reached, thereby making this measurement no longer worthwhile. Instead, we are now measuring the percent of completeness relative to other activities designed to mature and implement the target ITA and migration strategy-activities such as: completion of ITA segments for which subject-specific target architectures and migration strategies have been developed, compliance with the approved criteria used to certify architecture conformance, and use of System Design Reference Models for establishing configurations of platforms and tools for software development projects, development of IT policies and procedures that support the ITA, and integration of models and processes developed as part of the architecture into CMS's day-to-day activities.

Coordination: The CMS is coordinating the ongoing evolution of its architecture and migration strategy with other Department of Health and Human Services (HHS) representatives. This coordination occurs through regular meetings of the HHS CIO Council and its ITA Group.

Data Source(s): Approved standards and preferred IT products are documented in the IT standards profile database, which is accessible through CMS's Intranet. Current work is underway to document all IT policies in a standard manner. We intend to capture all these documented IT policies and associated procedures, templates, guides, etc. in a single repository as part of the Agency's IT Investment Management program (a/k/a "Roadmap"). Also, System Design Reference Models will be integrated into the Roadmap activities.

Verification and Validation: The CIO's Technical Advisory Board verifies and validates that project designs comply with: IT Standards Profile database, the System Design Reference Models, and other Enterprise Architecture conformance criteria.

FEDERAL ADMINISTRATIVE COSTS

Performance Goal FAC4-04

Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice

Baseline: Prior to the enactment of the BBA of 1997, SNFs, HHAs, hospital outpatient services, inpatient rehabilitation services and psychiatric hospitals were paid on a cost reimbursement basis (although certain limits applied). Payments to managed care plans were not risk-adjusted (did not reflect variations in per capita costs based on health status of beneficiaries).
FY 2004 Target: Implement PPS system for inpatient psychiatric hospital services. A new risk adjustment model for payments to M+COs that incorporates inpatient and ambulatory data will be implemented in CY 2004 and the collection of inpatient and ambulatory data will continue.
FY 2003 Target: Continue design of PPS system for inpatient psychiatric hospital services. Begin the combined collection of both inpatient and ambulatory data for the implementation of an improved Medicare+Choice risk adjustment methodology in CY 2004.
FY 2002 Target: Implement PPS systems for inpatient rehabilitation services during FY 2002. Design PPS systems for psychiatric hospitals. An improved risk adjustment model for payments to Medicare+Choice Organizations (M+CO) will be developed for implementation in CY 2004 and data systems will be implemented to capture both inpatient and ambulatory data. Performance: Goal met. The inpatient rehabilitation facilities (IRF) PPS rule was published in the Federal Register on August 7, 2001. IRF PPS was successfully implemented on January 1, 2002. A risk adjustment model for payments to M+COs has been selected that incorporates both inpatient and ambulatory data.
FY 2001 Target: Implement PPS systems for HHA services October 1, 2000. Risk adjusted payments to M+COs will continue to be made based on the PIP-DCG model; and the collection of inpatient data will continue in FY 2001. Performance: Goal met. The HHA PPS final rule was effective October 1, 2000.
FY 2000 Target: Implement PPS for hospital outpatient services. Make risk adjusted payments under Medicare+Choice. Publish final PPS regulation for HHA. Performance: Goal met. Risk adjusted payments began January 1, 2000 and hospital outpatient department PPS was implemented August 1, 2000. HHA PPS final rule published July 3, 2000.
FY 1999 Target: Establish methodology for SNF PPS and establish risk adjuster methodology for Medicare+Choice. Performance: Goal met.

Discussion: The Balanced Budget Act (BBA) of 1997 requires the development of a number of prospective payment systems (PPS) in traditional Medicare and a risk adjustment methodology for payments to Medicare+Choice plans. The categories of providers or services that are to be paid on a prospective basis include skilled nursing facilities (SNF), home health agencies (HHA), inpatient rehabilitation hospital services, and services provided in hospital outpatient departments. The Balanced Budget Refinement Act (BBRA) of 1999 requires the development of a PPS for psychiatric hospitals.

FEDERAL ADMINISTRATIVE COSTS

Prior to enactment of the BBA, SNFs, HHAs, hospital outpatient services, and inpatient rehabilitation hospital services were paid on a cost reimbursement basis (though certain limits applied). Prior to enactment of the BBRA, psychiatric hospitals also were paid on a cost reimbursement basis. Prospective payment for these services is expected to result in more efficient provision of care, and lower costs to the Medicare program. With regard to payments to Medicare+Choice plans, CMS, the Congressional Budget Office, and numerous researchers have found that, because of the relatively better health of Medicare Health Maintenance Organization (HMO) enrollees, the pre-BBA payment methodology can result in higher costs than fee-for-service Medicare. Based on BBA requirements, the Secretary implemented a risk adjustment methodology, on January 1, 2000, that accounts for variations in per capita costs based on health status. The Medicare, Medicaid and SCHIP Benefits Improvement Protection Act (BIPA) of 2000 further mandates that the risk adjustment methodology starting in 2004 should be based on data from inpatient hospital and ambulatory settings (Section 603).

Coordination: The CMS will work closely with its payment contractors in carrying out this goal.

Data Source(s): Required regulations and/or notices must be published in final in time to implement each provision.

Verification and Validation: We intend to further refine and improve the payment methodologies on a continuous basis. The CMS will use data and studies to determine appropriateness of the payment systems with a view towards continuous refinement.

FEDERAL ADMINISTRATIVE COSTS

Performance Goal FAC6-04**Improve CMS's Workforce Planning**

Baseline: Developmental. Baseline data to determine skill and knowledge gaps will be available from the workforce planning automated system in FY 2004.
FY 2004 Target: Update workforce planning data and establish a knowledge and skill level baseline.
FY 2003 Target: Complete development of and implement automated workforce planning modules.
FY 2002 Target: Build and populate an automated workforce planning system based on work roles. - Develop work roles (i.e., groupings of positions with similar functions and skill requirements), and assign each CMS position to a work role. - Determine future skill and knowledge requirements.
Performance: Goal met.

Discussion: Over the years, CMS's programs, structures, and workforce have changed significantly. Today, the organization faces a series of unprecedented business and environmental challenges, which have major implications for CMS's workforce. These challenges demonstrate a need to determine and address gaps in necessary skills and knowledge. The challenges are listed below:

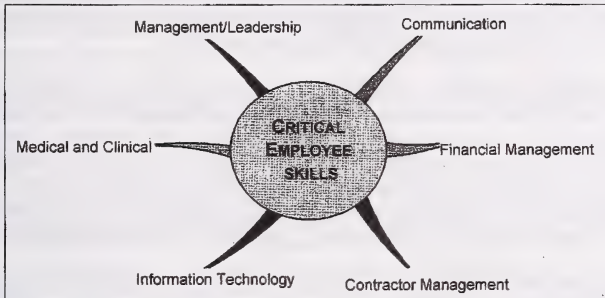
- (1) Financial Resources: Increased accountability for programmatic outcomes more closely linked to the budget;
- (2) Legislation: Major modifications to our programs as a result of legislation;
- (3) Human Resources: Aging workforce and competition for skilled workers;
- (4) Agency-wide Restructuring: New skills are required as CMS restructures itself to become more responsive to citizens and other stakeholders.
- (5) Increased Stakeholders: Increased program support to partners and stakeholders as beneficiary demographics change and demands grow;
- (6) Customers: The CMS's transition from a traditional role as payer and regulator into a broader role as an active market presence;
- (7) Technology: Rapid advancements in technology resulting in difficulty obtaining, developing, and retaining technology-related skills; and
- (8) Health Care Delivery: Rapid changes in medical practices and technology, requiring new and dynamic methods of oversight and regulation.

Given these challenges, and in accordance with the President's Management Plan, CMS is creating a dynamic workforce planning system to help managers make strategic plans and decisions for hiring/staffing, retention, and human resources development. The CMS workforce planning model will: (1) analyze current and future work; (2) develop a current and future competency framework; (3) identify existing workforce competencies; and (4) conduct an analysis of gaps between current and future requirements and existing workforce skills and knowledge. This four-phase process will be supplemented with

FEDERAL ADMINISTRATIVE COSTS

retirement, retention, and demographic analyses. This data serves as the basis for several action plans, including recruitment plans, succession plans, learning plans, and staffing/redeployment plans.

A gap is defined as the level of a skill or knowledge required in carrying out the agency's mission now or in the future, minus the level of that skill or knowledge available in the current workforce. During FY 2000, CMS leadership identified the following six broad competency areas as long-term priority workforce planning needs:



During FY 2001, CMS employees completed a Knowledge and Skills Inventory, identifying their current level of skills and knowledge as well as the levels required in their current positions. Skill and knowledge gaps identified through this one-time data collection initiative were ranked by agency management based on breadth, depth, and criticality for accomplishing CMS's strategic goals. This ranking resulted in the identification of gaps in specific knowledge and skills in each of the six areas listed above, as well as one cross-cutting skill (project management).

In FYs 2002 and 2003, we are implementing strategies to address the gaps in each of the seven knowledge and skill areas. The level of skill or knowledge in these targeted areas will be increased by strategic activities to recruit, develop, retain, and/or redeploy employees. These activities will be evaluated to determine their effectiveness in increasing knowledge or skills. In future years, the automated workforce planning system will be used to determine changes in workforce knowledge and skills.

Design of an intranet-based system to house workforce planning data was initiated in FY 2001. During FY 2002, a prototype system was developed. After evaluating the initial prototype, CMS decided to develop a series of automated workforce planning modules linked to our human resource information system, rather than build a "stand-alone" workforce planning system. Completion of these modules is expected in FY 2003. Full implementation, in FY 2004, will give CMS data on knowledge and skill gaps that can be tracked over time.

FEDERAL ADMINISTRATIVE COSTS

Coordination: Workforce planning is being done in accordance with guidelines and standards of the Department of Health and Human Services, the Office of Management and Budget, the Office of Personnel Management, and the General Accounting Office. The CMS is working with the American Federation of Government Employees, Local 1923, which represents staff.

C² Technologies, Inc. and the American Institutes for Research are developing the design for the automated workforce planning system through the Office of Personnel Management's training management assistance services. Within CMS, the Office of Internal Customer Support is programming the individual modules and coordinating with the Office of Information Services to implement the system.

Data Source(s): Beginning in FY 2003, a series of intranet-based workforce planning modules will house data on the number of full-time equivalents (FTEs) performing each of CMS's business functions and roles, the skills and knowledge required to carry out the functions and roles, and the skills and knowledge of current CMS staff. Employees and managers will be able to access and update information on themselves or their organizations. These modules, when operational, are expected to provide the data for periodic reports on the status of the agency's skill and knowledge requirements.

Verification and Validation: All CMS staff will be expected to provide data on skill and knowledge levels; sampling will not be used. The automated workforce planning modules will allow for managerial validation of skill and knowledge data and employee validation of data provided by managers. The data for the automated system is being collected using standard job analysis and other behavioral science techniques, which include validation procedures.

FEDERAL ADMINISTRATIVE COSTS

Performance Goal FAC7-04

Improve CMS's Management Structure

Baseline: Developmental.
FY 2004 Target: Performance Management: Establish a baseline using data from the automated management competency system.
FY 2003 Target: (a) Performance Management: Full implementation of a competency-based performance management (planning and appraisal) program for non-Senior Executive Service (non-SES) managers; (b) Awards and Recognition: Implementation of an awards and recognition program for non-SES managers directly linked to managerial effectiveness and program results; and (c) Explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of LMDS activities.

Discussion: The CMS faces a number of human resource challenges in the next several years, including the increasing number of managers eligible for retirement. In order to address this challenge, we have had to reevaluate the development and growth of our managers. Like many other Federal agencies, CMS has often chosen managers based upon their technical expertise with little emphasis on their leadership skills. The CMS has initiated a Leadership and Management Development Strategy (LMDS) to build proficiency in the disciplines of leadership and management by developing systems and practices that promote a high standard of leadership throughout the Agency.

The LMDS is based on a set of 5 competencies, encompassing 28 related skills. The five competencies are based on those used by the Office of Personnel Management for members of the Senior Executive Service. The intent is to build proficiency throughout the Agency in the disciplines of management and leadership by developing systems and practices that promote a high standard of leadership that is both results-oriented and customer-focused. These proficiencies will enable CMS managers to become better stewards of the programs entrusted to the Agency by the public. The LMDS addresses a wide range of activities, including performance management and awards and recognition, which comprise our FY 2003 targets, along with recruitment and selection and continuous learning, which are efforts that are already in progress.

Recruitment and Selection

Many Government managers are often selected on the basis of their personal technical expertise, without emphasis on demonstrated leadership skills. Novice managers who do not receive timely training and mentoring for their new roles often continue to function as technical leads with a few added administrative duties.

In 1999, CMS introduced a new process, on a pilot basis, for recruiting and selecting managers based on the five managerial competencies—managing change, leading people, producing results, managing resources, and partnering/building coalitions. Working from the list of 28 competency-related Knowledge Skills and Abilities (KSAs), selecting officials chose the KSAs that were most important for the position being filled, with all five managerial competencies being represented, in addition to technical KSAs, specific to a CMS program or function. In this way, a balance was maintained between the

FEDERAL ADMINISTRATIVE COSTS

desired technical and managerial selection criteria. Full implementation of the competency-based recruitment and selection process for non-SES managers was fully implemented effective March 4, 2002.

Performance Management

Performance management (planning and appraisal) programs fulfill five organizational purposes: 1) linking individual performance to the organization's mission and objectives; 2) defining what constitutes acceptable performance; 3) measuring and evaluating individual performance; 4) relaying information about current performance back to individuals to shape their future performance; and 5) providing information to related management systems (such as compensation or succession planning).

The CMS is working to introduce a performance planning and appraisal program for non-SES managers that will encourage managers to discuss, develop and apply the managerial competencies. One of our targets is to have this performance management program fully developed in FY 2003.

In line with the Performance Management Program for managers (i.e. appraisal and awards and recognition systems), in FY 2003, CMS is developing an automated system (form and database) that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports. This information will allow us to determine the management competencies most used in CMS and to track ratings from year to year. The theory is if the human resources processes consistently support these core management competencies; that is, we recruit and select based on these competencies, managers are rated against these competencies, our management training focuses on these competencies and managers are rewarded for demonstrating these competencies, the current culture will change and CMS managers will become better leaders.

We will gather baseline data from the automated system in FY 2004 to begin measuring improvement in the leadership competencies.

Awards and Recognition

Any attempt to implement a competency-based approach to management must recognize all competencies, both programmatic and managerial. To support competency-based recruitment and hiring and performance management, CMS will develop an awards and recognition program for non-SES managers in FY 2003.

Continuous Learning

Using a managerial competency-based model for management is the foundation for improved recruitment and selection, performance management, and awards and recognition for CMS managers.

To that end, CMS has identified a core set of classroom learning opportunities that will help managers, both new and established, acquire and become proficient in basic management skills. The initial set of courses was first offered in FY 2001, and we

FEDERAL ADMINISTRATIVE COSTS

continue to identify additional courses and other learning opportunities. In FY 2002 we revised requirements to make the core management learning opportunities mandatory for probationary managers and to make a reasonable number of continuing management education classes mandatory in each year after completion of probation for all managers.

Coordination: The goal to improve CMS's management structure is being conducted in accordance with a modified approach used by the Office of Personnel Management for members of the Senior Executive Service. All activities in this regard are undertaken with the concurrence of the LMDS Advisory Panel and the CMS Leadership Development and Recognition Board.

Data Source(s): Developmental. In FY 2003, CMS is developing an automated system that will be used in both the appraisal and awards systems to capture managerial performance information and to issue management reports.

Verification and Validation: Developmental. The selected CMS managerial competencies were validated in the Agency under contract with Wilson Learning. All management evaluations, including competency information to be entered into the automated system, are reviewed at the Office/Center Director and Regional Administrator level through the management reporting feature of the automated system.

FEDERAL ADMINISTRATIVE COSTS

Performance Goal FAC8-04

Strengthen and Maintain Diversity at all Levels of CMS

Baseline: Comparing the CMS Workforce with the National Civilian Labor Force (CLF), in FY 2000, there were Equal Employment Opportunity (EEO) groups that exhibited manifest imbalance in the CMS workforce.
FY 2004 Target: Increase the representation of EEO groups in areas where they demonstrate underrepresentation.
FY 2003 Target: Increase the representation of EEO groups in areas where they demonstrate underrepresentation.

Discussion: Workforce diversity has evolved from sound public policy to a strategic business imperative. Federal diversity initiatives have historically focused on equal employment opportunity (EEO) and affirmative employment. The Federal Government must now broaden its view of diversity. We must embrace the business, cultural, and demographic dimensions of diversity as well as the legal dimension. Focusing on diversity and looking for more ways to be a truly inclusive organization--one that makes full use of the contributions of all employees--is not just a nice idea; it is good business sense that yields greater productivity and competitive advantage. Diversity management programs are recognized as being a critical link in achieving the Agency's specific mission or business needs, relative to employees, customers, suppliers, and other stakeholders. This is the business case for valuing diversity.

The business case for diversity has two significant elements. First, the labor market has become increasingly competitive. We must use every available source of candidates to ensure that we have the high-quality workforce needed to deliver our mission to the American public. It is an intangible asset for an organization to have a good public perception. Being recognized as an organization that values diversity contributes to a positive image which in turn will attract the best and the brightest employees. As the value of diversity continues to grow in the business community and elsewhere, recruiting and retaining talented employees who are diverse is becoming even more important to an organization's success. Second, the changing demographics of America mean that the public served by CMS is also changing. When we recruit and retain an inclusive workforce--one that looks like the America we serve--and when individual differences are respected, appreciated, and valued, diversity becomes an organizational strength that contributes to achieving results. A byproduct of capitalizing on differences is creativity. Historically, some of the most creative periods in civilization have emerged when people of different backgrounds had contact. Employees from varied backgrounds can bring different perspectives, ideas and solutions to use in strategic planning, problem solving, and decision making. It enables us to better serve the taxpayer by reflecting the customers and communities we serve.

All Federal agencies strive for "parity"¹ with the Civilian Labor Force. By doing so, we ensure the diversity we seek, since the Civilian Labor Force is comprised of persons

¹ Parity exists when an EEO group's Agency workforce representation is equal to the Civilian Labor Force.

FEDERAL ADMINISTRATIVE COSTS

age 16 and over, excluding those in the armed Forces, who are employed or seeking employment.

Workforce diversity is characterized along a continuum of 1) parity, 2) near parity, 3) manifest imbalance and 4) conspicuous absence.² On the road to achieving parity in its workforce, CMS must first reduce the manifest imbalances that currently exist.

Federal agencies are required by regulation to monitor the representation of all EEO groups each year and to report Agency activities and accomplishments to the Equal Employment Opportunity Commission and the Office of Personnel Management (OPM). Strategies that will bring improvement include: communicating the Agency leadership's strong commitment to diversity, workforce planning, conducting effective outreach and recruitment, utilizing hiring flexibilities, maintaining a supportive work environment, providing development and training opportunities (upward mobility programs), monitoring activities and making adjustments as needed, establishing accountability, reward success and continuously educate and communicate the value of diversity.

Coordination: Department of Health and Human Services; Equal Employment Opportunity Commission; OPM (Federal Equal Opportunity Recruitment Program (FEORP)); Department of Labor, Office of Disability Employment Policy; State Vocational Rehabilitation Agencies; national colleges and universities (including Historically Black Colleges and Universities, Hispanic Serving Institutions, and Tribal Colleges and Universities); Federal Asian Pacific American Council; Organization of Chinese Americans; National IMAGE; League of United Latin American Citizens, National Council of LaRaza; National Hispanic Leadership Conference; National Society of Hispanic MBAs; Blacks in Government; National Association for the Advancement of Colored People; National Congress of American Indians; and Association of American Health Plans, Minority Management Development Program.

Data Source(s):

- Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 1990 official decennial census figures³
- The 1990 official decennial census figures
- OPM's Central Personnel Data File (updated every pay period)
- HHS' Workforce Inventory Profile System (WIPS) (updated every pay period)
- The CMS Workforce Profiles (prepared using (WIPS))

Verification and Validation:

- 1990 Civilian Labor Force data - Validated and verified by the Census Bureau

² Conspicuous Absence occurs when an EEO group's Agency workforce representation is between 0 and 20% of the Civilian Labor Force.

³ EEOC Office of Public Sector Programs requires agencies to use current, official Census Bureau Civilian Labor Force data to calculate under-representation indices. The Census Bureau is in the process of analyzing 2000 census data by occupation category and code. The Census Bureau estimates that verification and validation will be completed in 2003 and that official figures will be available in late 2003.

FEDERAL ADMINISTRATIVE COSTS

- Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 1990 official decennial census figures - Validated and verified by OPM. These are the standard government-wide statistics.
- Central Personnel Data File - Validated and verified by OPM.
- HHS' Workforce Inventory Profile System (WIPS) - Validated and verified by HHS.
- The CMS Workforce Profiles - Validated and verified by CMS.

FEDERAL ADMINISTRATIVE COSTS

Performance Goal FAC9-04

**Increase Awareness of the Opportunity to Enroll in the
Medicare Savings Programs**

Baseline: In FY 2002, 11 percent of Medicare beneficiaries were aware of Medicare Savings Programs.
FY 2004 Target: Increase awareness of Medicare Savings Programs to 14 percent.
FY 2003 Target: Increase awareness of Medicare Savings Programs to 13 percent.
FY 2002 Target: Develop baseline and set future targets.
Performance: Goal met

Discussion: Although Medicare provides beneficiaries with a basic set of health benefits, the beneficiaries are still required to pay a significant amount out-of-pocket for premiums, deductibles and co-insurance. These costs can be prohibitive for many beneficiaries, particularly for the approximately 12 percent who do not have private or public supplemental insurance. This performance goal will seek to increase awareness of State programs that can assist low-income Medicare beneficiaries with their Medicare cost-sharing expenses.

The Medicare Savings Programs enacted to help Medicare beneficiaries with their cost-sharing expenses include, among others, Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), Qualified Disabled and Working Individual (QDWI), and Qualifying Individual (QI).

In the initial years of this endeavor, we will emphasize awareness to individuals who are eligible for the QMB and SLMB programs. These programs were enacted to help low-income Medicare beneficiaries with their Medicare cost-sharing expenses. States are required to pay for the premiums, deductibles, and cost sharing for QMBs. For SLMBs, they are required to pay for the Part B premium. Despite the existence of these programs, a substantial proportion of individuals eligible for these programs are not enrolled (e.g. two recent studies estimated non-participation rates for QMB to range from 40-60 percent).

Since enactment of the QMB and SLMB provisions, CMS has undertaken a number of outreach initiatives directed at providing awareness of the programs. These efforts include development of brochures for targeted populations such as: African American, Hispanic, Asian American Pacific Islander, American Indian/Alaskan Native, caregivers, and the disabled. These brochures are available on the Medicare.gov website. Information regarding the Medicare Savings Programs is available in CMS publications such as: the *Medicare & You* handbook (which includes information about the programs, and provides a toll-free telephone number for beneficiaries to call for more information) and the Guide to Health Insurance for People with Medicare. Additionally, the Regional Education About Choices in Health (REACH) Campaign through community-based outreach activities and regional materials will continue to educate Medicare beneficiaries

FEDERAL ADMINISTRATIVE COSTS

on the Medicare Savings Programs. The State Health Insurance Assistance Programs (SHIPS) provide assistance through individual counseling and group education activities to educate Medicare beneficiaries about the programs. The SHIPS are kept abreast of all activities related to the Medicare Savings Programs. In addition, CMS has partnered with the Social Security Administration (SSA) and provided state-specific language that was used in letters to potentially eligible Medicare beneficiaries who appeared to meet the income criteria of the QMB/SLMB and QI-1 programs. CMS also provides alerts and other information on these mailings to Regional Offices and to SHIPS. The mailing targeted 16.5 million Medicare beneficiaries. SSA conducted the mailing based on a mandate under section 1144 of the Social Security Act. SSA will conduct annual mailings.

The CMS also has provided interested States with identifying information about newly eligible Medicare beneficiaries who are potential candidates for the State programs. In order to achieve our goal we are working with States, the advocacy community, and other interested parties to develop a comprehensive strategy to increase awareness about Medicare Savings Programs.

Coordination: The CMS has conducted a number of activities in the area of outreach in partnership with other Federal agencies, States, providers, and community organizations. These activities included: direct mailings to beneficiaries and grants to State Health Insurance Assistance Programs (SHIPS), States, ombudsman and information intermediaries for outreach. The CMS will continue to use various channels of communications and information intermediaries to increase Medicare beneficiary awareness about the opportunity to enroll in programs that might be able to assist them with their Medicare cost-sharing expenses. Outreach strategies will only be able to be fully realized through the continuation of the partnerships that have been formed with other Federal agencies, such as the Social Security Administration and the Health Resources and Services Administration.

Data Source(s): The primary source of data on beneficiary awareness of the Medicare Savings Programs will be the Medicare Current Beneficiary Survey (MCBS). The CMS will track progress for this goal using MCBS data. The MCBS is an on-going personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage. The MCBS includes questions that ask beneficiaries about their awareness of programs that are open to seniors and persons with disabilities who have limited financial resources and need help paying Medicare-related costs. The measure will only include low-income beneficiaries.

The questions are in a "yes," "no," and "don't know" format. For ethical reasons, after asking questions, MCBS interviewers will make the correct answers to the questions available to the respondents (beneficiaries cannot inadvertently be left with any misperceptions about the program). Therefore, the act of surveying these respondents would confound subsequent measurement of their awareness of the program features.

FEDERAL ADMINISTRATIVE COSTS

Sampled beneficiaries remain in the MCBS for 3 years and then rotate out of the survey. Thus, each year about one-third of the overall MCBS sample is new and two-thirds are returning. To avoid instrumentation bias, the measure will only include new MCBS members. This new part of the MCBS sample is itself nationally representative of the Medicare population.

Verification and Validation: All data from the MCBS are carefully edited and cleaned prior to the creation of analytic data files. Sample weights will be prepared that allow adjustments to survey estimates to account for differential probabilities of selection in the MCBS sample, under-coverage, and differential patterns of survey non-response. Statistical precision will be calculated and presented with the estimates.

FEDERAL ADMINISTRATIVE COSTS

Performance Goal FAC10-04

**Implement CMS Restructuring Plan to
Create a More Citizen-Centered Organization**

Baseline: CMS FY 2002 FTE Ceiling of 4632 and up to five management levels in the organization as of January 01, 2002.

FY 2004 Target: Developmental

FY 2003 Target: 1. Achieve greater administrative efficiency through consolidation of administrative functions and enhance the delivery of citizen-centered services by developing strategies that will enable the reduction of administrative FTE by 93 without substantially reducing the level of administrative services necessary to maintain CMS's operational efficiency. 2. Achieve a more citizen-centered focus through organizational de-layering, from five layers to four, in 16 CMS components.

Discussion: In support of the President's Management Agenda, the Secretary directed the Department of Health and Human Services (DHHS) to consolidate administrative functions for all Operating Divisions (OPDIV) to achieve greater administrative efficiency. The resultant improvements in administrative efficiency will enable OPDIVs to significantly reduce the FTE required to perform administrative functions, and will thus allow OPDIVs to transfer these FTE resources into positions responsible for the direct provision of citizen-centered services. Along these lines, by the end of FY 2003, CMS will reduce administrative (e.g., human resources, facilities management, budget and finance, information technology (IT), procurement, and grants management) FTE usage by 93 (from the projected FY 2002 usage). These reductions will be achieved using either attrition (with vacant FTE transferred to direct citizen-centered service positions) or the re-deployment of incumbents into direct citizen-centered service positions. Voluntary Early Retirement Authority (VERA) was approved for CMS in August 2002 to assist in reducing the targeted administrative function FTEs via attrition. As of December 2002, some 40 individuals have filed a "statement of interest" relevant to VERA, and 11 individuals have filed actual VERA retirement applications. CMS requested and was granted a 90-day extension (through September 2003) in this authority, which we believe could result in a further reduction of some 5-10 administrative FTE and a corresponding re-deployment of staff to line positions.

In order to achieve the administrative efficiencies necessary to allow for reduction of 23 FTEs in the human resources (HR) area without compromising requisite levels of internal administrative support, CMS is working closely with DHHS to maximize consolidation of HR functions and intra-Departmental cross-servicing arrangements to establish significantly improved "economies of scale." The CMS is also exploring enhancements to its HR automation environment to help facilitate HR FTE reduction. We implemented a major restructuring of the CMS Human Resources Management Group in June 2002 to separate the HR strategic consulting function from the classification and staffing operations in order to position ourselves to better evaluate competitive sourcing, shared servicing, and automation options. Again, we believe that this initiative will enable us to better absorb the loss of administrative FTE targeted for the HR function.

FEDERAL ADMINISTRATIVE COSTS

In addition to the elimination of the 93 FTE addressed above, CMS is supporting the consolidation of public affairs and legislative functions within DHHS, resulting in a transfer of 63 full-time equivalents (FTEs) from CMS to the Office of the Secretary. A final effective date has not been set.

The CMS developed and submitted to DHHS a Hiring Plan for fiscal year 2002, and a Restructuring Action Plan to achieve the restructuring objectives for administrative efficiency and de-layering. CMS is in the process of developing its final FY 2003 hiring plan, and this plan will continue to reflect strong adherence to restructuring and de-layering principles. Through these plans, we hope to further our goal of creating a more citizen-centered, diverse, high quality workforce at all levels of the Agency. Further restructuring activities for FY 2004 will be targeted pending additional guidance.

In general, all CMS administrative functions, such as budget and financial management, human resource management, public affairs, and legislative affairs are already consolidated at the OPDIV level, except where sound business reasons dictate otherwise. Many of the specific steps detailed in the Action Plan refine current business operations of consolidated functions to improve efficiency and service delivery. For example, where financial operations occur outside the direct line authority of the Chief Financial Officer (CFO), the Agency's Financial Management and Investment Board (FMIB), which reports directly to the Deputy Administrator and Chief Operating Officer, has financial oversight responsibility. In the area of IT, CMS awarded the Consolidated Information Technology Infrastructure Contract (CITIC) in May 2002. Under CITIC, CMS has combined multiple IT infrastructure support contracts (data center, network services, telecommunications, etc.) into a consolidated contract managed by the Office of Information Services.

We have identified all organizations in which we have more than the target level of four management layers for the Agency, and have developed plans and organization charts for achieving the goal of four management levels. De-layering efforts for 15 of the 16 organizations identified under this initiative have already been completed, and the reorganization package for the final identified organization is currently being reviewed. We anticipate that this final targeted organizational effort will be successfully concluded shortly. Moreover, we have identified and eliminated many of the double deputies that presently exist in the Agency. We are confident this will help us achieve a more citizen-centered focus and will complement many of the other citizen-centered initiatives already in place within CMS.

The number of FTEs reduced through streamlining/consolidation activities is currently being measured. The CMS organization structure will be used to determine the target of four management levels. We will compare the difference between CMS's FY 2002 baseline FTE ceiling of 4632 and the number of management levels in the organization as of January 1, 2002 to the actual levels achieved for both of these data sources by the end of FY 2003.

FEDERAL ADMINISTRATIVE COSTS

Coordination: The goal to implement a CMS Restructuring Plan to create a more citizen-centered organization is being coordinated with the Office of the Assistant Secretary for Administration and Management.

Data Source(s): The CMS Employment Status Report, which tracks FTE ceiling, gains and losses, will be used to measure FTE reduction. The CMS Organizational charts will determine the target for organizational de-layering.

Verification and Validation: Internal checks of the information are regularly performed.

RESEARCH

Research, Demonstration, and Evaluation

Research, Demonstration, and Evaluation	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Budget Authority	\$138.3 M	\$117.2 M	\$28.4 M	\$63.4 M

The Research, Demonstration and Evaluation program supports CMS's role as a beneficiary-centered purchaser of the highest quality health care at the lowest possible cost. The CMS performs, coordinates, and supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of CMS's programs on its beneficiaries, providers, States, and other customers. This role requires the development, implementation and evaluation of a variety of innovative, new demonstration projects as well as expanded efforts to evaluate the effectiveness of CMS's current programs. These research responsibilities include evaluations of the Medicare and Medicaid programs and the State Children's Health Insurance Program.

Other representative goals that are related to this budget category but are not listed in the chart are:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive (MB1-04)
- Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice (FAC4-04)

Performance Goal	Targets	Actual Performance	Ref.
Assess the relationship between CMS research investments and program improvements	FY 04: Conduct internal assessment FY 03: Conduct internal assessment FY 02: Repeat internal and external assessments FY 01: Repeat internal assessment; conduct initial external review FY 00: Conduct internal and external assessments FY 99: Develop goal for FY 2000	FY 04: FY 03: FY 02: Internal assessment and external review completed (Goal met) FY 01: Internal assessment and external review completed (Goal met) FY 00: First internal assessment conducted; External review delayed FY 99: Goal developed (Goal met)	R1 See FY 03 Revised Final 

RESEARCH

Performance Results Discussion

Research - Assessing the impact of research and demonstration activities is challenging. In many cases the anticipated effects are long-term outcomes. In addition, proving a direct correlation between a research intervention and a given result can be very difficult, particularly in the field of health care where multiple variables can cloud the analysis.

We met our FY 2002 target by conducting internal and external assessments of CMS research. The external reviewers echoed the overall conclusions of the FY 2001 external reviewers in finding the internal assessments to be a careful and thoughtful review of CMS research. Overall, the reviewers found our characterization of the accomplishments and limitations in each research area to be accurate. They found the internal assessment to be useful for understanding how CMS has approached its research responsibilities and for assessing future research needs. The FY 2002 external reviewers did, however, feel strongly that annual assessments are too frequent to accurately assess the results of multiyear research agendas.

Based on the recommendations made by the external reviewers and CMS research leadership, we plan to continue annual internal assessments and to further integrate them with our work planning and budgeting processes. However, we will move to a 3-year cycle for the external assessments and conduct our next one in FY 2005.

For FY 2003, we plan to perform an internal assessment that covers the events of the past year - both project accomplishments and modifications in research plans in response to new and evolving priorities. We will also take the recommendations of past external reviewers into account as we refine our internal assessment process. We will report on the status of our FY 2003 internal assessment by the end of FY 2003.

RESEARCH

Performance Goal R1-04

Assess the Relationship between CMS Research Investments and Program Improvements

FY 2004 Target: Conduct internal assessment.
FY 2003 Target: Conduct internal assessment.
FY 2002 Target: Repeat internal and external assessments. Performance: Goal met – internal assessment and external review completed.
FY 2001 Target: Repeat internal assessment. Conduct initial external review. Performance: Goal met – internal assessment and external review completed.
FY 2000 Target: The baseline internal performance assessment will be conducted between August 1999 and February 2000. For this initial year, the external review of the internal assessment will be carried out between February and August 2000. Performance: Goal partially met - internal assessment conducted; first external review delayed.
FY 1999 Target: Develop a goal. Performance: Goal met.

Discussion: The purpose of CMS's research program is to provide CMS and the health care policy community with objective analyses and information to foster improvement in CMS programs and to guide the Agency in its future direction. The CMS's research and development (R&D) functions are to develop, test and implement new health care financing policies and to monitor and evaluate the impact of CMS's programs on its beneficiaries, providers, States, and other customers and partners. In addition, CMS's research program produces a body of knowledge that is used by Congress, the Executive Branch, and the States to improve the efficiency, quality, and effectiveness of the Medicare, Medicaid, and State Children's Health Insurance programs.

A regular systematic review and assessment of CMS's research program is important to ensure that CMS's beneficiaries obtain maximum benefits from R&D spending. The CMS's performance on this goal is measured using a formal annual internal assessment that is reviewed and evaluated by external experts. The internal assessment is dovetailed with the development of the 2-year research plan and budget, which involves consultation with all CMS components regarding their research needs. In turn, each CMS component with projects in the research budget will be responsible for performing the internal assessment of their projects.

We have found that annual internal assessments are a useful way to monitor our ongoing R&D activities. However, the external review benefits from a broad multiyear perspective, and we believe that the external process can more effectively be conducted every 3 years. Therefore, beginning in FY 2003, we will continue to conduct internal assessments on an annual basis, but we will only perform external assessments every

RESEARCH

three years. After the FY 2002 external assessment, the next external assessment will not occur until FY 2005.

Coordination: Coordination of CMS R&D activities with other Federal and State organizations, non-profit research foundations, colleges and universities, private research firms, research components of trade organizations, and advocacy groups takes place regularly on a variety of levels. The CMS staff regularly participates in the annual conferences of groups such as the American Public Health Association and the Association for Health Services Research, as well as professional meetings of social science associations. These contacts are important in defining CMS's R&D agenda, avoiding duplication of effort, stimulating research on CMS issues by researchers outside of CMS, and generally increasing the productivity of CMS R&D.

Data Source(s): The CMS developed an assessment report for evaluating its research efforts. Data sources used for this report include the CMS R&D Plan, legislation that mandates CMS research activities, and other documents produced under CMS research, demonstration, and evaluation projects.

Verification and Validation: The application of research effectiveness criteria combines internal self-assessment and review by external experts. All CMS components responsible for research and demonstration projects are involved in the self-assessment process. The external experts are drawn from highly credible researchers familiar with both CMS programs and the national scope of health care research.

REVITALIZATION PLAN

Revitalization Plan

Revitalization Plan	FY 2001 Actual	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
Total Budget Authority	N/A	N/A	N/A	\$65.0 M

The CMS Revitalization Plan is a new, multi-year investment that will fund fundamental infrastructure improvements, modernize systems and operations, and bring Medicare and Medicaid operations into the modern era.

The first step in this revitalization process focuses on four major challenges involving information technology (IT). Revitalization Plan activities scheduled for FY 2004 include mitigating systems security risks at CMS and our Medicare contractors, modernizing Medicare fee-for-service claims processing, modernizing several databases vital to Medicare and Medicaid program operations, and modernizing CMS IT infrastructure to support a secure e-government/e-commerce environment.

Other representative goal(s) that relate to this budget category but are not listed in the chart are:

- Increase the Use of Electronic Commerce/Standards in Medicare (MO3-04)
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries (MO8-04)
- Improve Beneficiary Understanding of Basic Features of the Medicare Program (MO9-04)

REVITALIZATION PLAN

Performance Goals	Targets	Actual Performance	Ref.
Improve CMS's Information Systems Security:	FY04: --Achieve zero material weaknesses --Accredit security plans --Fund corrective action plans for Medicare contractors --Publish security standards in CMS ITA --Establish policies for automation of paper-based processes		RP1 Formerly FAC3 See FY 03 Revised Final
	FY 03: -- Eliminate all material weaknesses -- Implement access control management system	FY 03:	2
	FY 02: -- Eliminate all material weaknesses -- Evaluate Medicare contractors' security profile and apply baseline to CMS's business partners -- Implement intrusion detection & response procedure	FY 02: --Expect to meet (Results avail Jan 2003) --Evaluation complete (Goal met) --Implemented April 02 (Goal met)	
	FY 01: -- Eliminate all material weaknesses -- Increase percent of employees receiving security training to 95% -- Increase proportion of Medicare contractor sites receiving security review	FY 01: -- One weakness (Goal not met) -- 20% CBT delayed (Goal not met) --One-third (Goal met)	
	FY 00: -- Eliminate all material weaknesses	FY 00: -- one weakness (Goal not met) FY 99: two weaknesses FY 97: five weaknesses (Baseline)	

Performance Results Discussion

Information Systems Security – The CMS has created a goal to improve its information systems security policies and practices enterprise-wide. Evaluations have been completed on high-risk Medicare contractors and CMS has begun funding projects to close the gaps between the security profiles and core security requirements. A corrective action plan was created to address the material weakness of the Electronic Data Process (EDP) portion cited in CMS's FY 2001 CFO report for both Central Office and Medicare contractor systems. The 2002 CFO audit results will not be available until January 2003 however, the target is expected to be met. A computer-based training (CBT) package was deployed to all personnel to increase the number of employees receiving training. This program was prolonged due to a major rewrite to

REVITALIZATION PLAN

include section 508 of the Americans with Disabilities Act, therefore the FY 2001 target to have 95 percent of CMS employees receive security awareness training carried over into 2002. In April 2002, CMS implemented an intrusion detection capability and incident response procedure documentation was prepared and distributed for comment. The CMS has reviewed the comments and prepared a draft final document, which was submitted to CMS's CIO Technical Advisory Board (CTAB) for their review.

We are confident the program will result in continued improvement in the security posture of CMS and are optimistic that future goals will be met.

REVITALIZATION PLAN

Performance Goal RP1-04

Improve CMS's Information Systems Security

Baseline: The 1997 OIG electronic data processing (EDP) audit for CMS's Central Office showed one material weakness and 31 reportable conditions, and four material weaknesses and 102 reportable conditions for Medicare contractor systems. In Central Office, there was a material weakness in the control of access to production data. In the contractor area, there was one material weakness in physical access and three in the control of local modifications or overrides to shared system applications and edits programs. Reportable conditions were found in all seven categories of evaluation.
FY 2004: Achieve zero material weaknesses in the CFO EDP Controls Audit. Security plans accredited for CMS General Support Systems. Fund corrective actions at Medicare contractors to the extent of available resources. Implement host-based IDS on mission-critical CMS systems. Minimum security standards for CMS systems are formally published in the CMS IT Architecture. Establish digital signature and encryption policies to enable automation of paper-based administrative processes.
FY 2003: Achieve zero material weaknesses in the EDP portion of the FY 2003 CFO audit. Implement improved access control management system.
FY 2002: Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Evaluate the highest risk Medicare contractors' security profiles against a comprehensive baseline of security requirements. Begin to apply the comprehensive baseline of security requirements to CMS's business partners. Implement an intrusion detection capability and document an incident response procedure. Performance: Goal pending CFO report.
FY 2001: Achieve zero material weaknesses in EDP portion of the FY 2001 CFO audits. In addition, 95 percent of CMS employees will receive security awareness training; and CMS will complete site security reviews for its Medicare payment contractors. (Each contractor will be reviewed once every 3 years.) Performance: Goal not met, one material weakness.
FY 2000: Achieve, for both Central Office and Medicare payment contractor systems, zero material weaknesses in the EDP portion of the FY 2000 CFO audit. Performance: Goal not met, one material weakness being explored for closure.

Discussion: As CMS moves further into on-line activity, with increased business partners and technological complexity, the protection of confidential information becomes even more critical. The CMS is fully committed to fulfilling its stewardship responsibilities for the information contained in its data systems and transported across its networks.

In the FY 2001 CFO audit, one material weakness was cited. A corrective action plan was created to address this weakness. Under this plan, a mitigating protocol establishing strict controls over local program changes has been created and field-tested. Beginning in 2002, all data centers running Fiscal Intermediary Standard System (FISS) are subject to review using this protocol. The results of the 2002 CFO audit will not be available early 2003.

REVITALIZATION PLAN

The CMS developed a multiple year Medicare Contractor Systems Security Plan for FY 2000. This plan requires contractors to have comprehensive security programs covering administrative, physical and technical safeguards based on a current specific set of core requirements, which include security requirements from OMB, GAO, IRS, Presidential Decision Directives (PDD) 63, and HIPAA.

In FY 2002, CMS completed evaluation of the highest risk Medicare contractors' security profiles against the comprehensive baseline of security requirements. Medicare contractors proposed 1,602 needed safeguards in the 2001 CAST security assessment to comply with CMS's baseline security requirements at a cost of \$70 million. In March 2002, CMS funded 642 proposed safeguards at a cost of \$4.8 million. In August 2002, CMS funded an additional 174 safeguards and 53 system security plans at a cost of \$9.7 million. Many of these safeguards have recurring costs that will be absorbed in the regular Medicare contractor budget. The CMS operating budget for FY2003 does not allocate funds to Medicare contractors to implement systems security requirements because of the funding provided in August 2002.

The CMS's strategy is to complete the evaluation process of all other Medicare contractors and to close the gaps identified. The evaluation process will be accomplished through Statement of Auditing Standards (SAS70) and Chief Financial Officers (CFO) reviews and CMS will then begin a comprehensive evaluation of the effectiveness of all contractor security activities.

The CMS also implemented an intrusion detection capability on the first of three ingress points on the network in April 2002. Incident response procedure documentation was prepared and distributed for comment. The CMS has reviewed the comments and prepared a draft final document, which was submitted to CMS's CIO Technical Advisory Board (CTAB) on September 25, 2002, for their review.

In accomplishing the goals outlined above, CMS is ensuring that we are in compliance with the Government Information Security Reform Act (GISRA). GISRA underscores the activities of the agency.

Coordination: The scope of enterprise systems security spans across the data, applications, and infrastructure services supporting all of CMS's business areas. We have formulated a systems security management framework to achieve the systems security improvement goals systematically. The CMS's Office of Information Services will work with CMS internal/external business managers and data owners to assess current security posture, establish target positions, and formulate transition plans.

Data Source(s): The CMS will retain training documents, to include computerized documentation in support of Computer Based Training (CBT) for all CMS users, and copies of public service announcements. For the remaining portions of the target, OIG audit findings, CMS's review findings and associated corrective actions tracking database (under development) will be the primary data sources for the CFO audit portion of this goal.

REVITALIZATION PLAN

Verification and Validation: Attendance records will be retained for security training and may be validated. Validation may be performed through checks of sign-in-sheets. Audit and review findings are reviewed by information security personnel and verified by systems owners.

APPENDIX A

PART III – APPENDIX TO THE PERFORMANCE PLAN

A.1 Linkage to HHS and CMS Strategic Plans

A key concept underpinning the GPRA law is the close linkage of an agency's strategic plan, performance plan, and its budget. The next few pages illustrate the linkages of the FY 2004 Annual Performance Plan goals to the draft FY 2003-2008 HHS Strategic Plan and the new CMS Strategic Plan.

**LINK OF FY 2004 CMS PERFORMANCE GOALS AND
THE DRAFT FY 2003-2008 HHS STRATEGIC PLAN**

FY 2004 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
Medicare Benefits								
Improve Satisfaction of Medicare Beneficiaries with the Health Care Services			✓		✓			
Improved Medicare's Administration of the Beneficiary Appeals Process					✓			
Quality of Care: Quality Improvement Organizations								
Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal	✓		✓					
Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram	✓		✓					
Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Diabetic Eye Exams	✓				✓			
Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection	✓				✓			
Quality of Care: Survey & Certification								
Decrease the Prevalence of Restraints in Nursing Homes			✓		✓			
Decrease the Prevalence of Pressure Ulcers in Nursing Homes			✓		✓			
Improve the Management of the Survey and Certification Budget Development and Execution Process					✓			✓
Grants to States for Medicaid/Medicaid Agencies								
Increase the Percentage of Medicaid Two-Year Old Children Who Are Fully Immunized	✓						✓	
Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates								✓
Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (CHIP)					✓			

APPENDIX A

FY 2004 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
State Children's Health Insurance Program								
Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid			✓					
Clinical Laboratory Improvement Amendments (CLIA)								
Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver					✓			
Medicare Integrity Program								
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Services Program			✓					✓
Assess Program Integrity Customer Service			✓					✓
Improve the Provider Enrollment Process			✓					✓
Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Exchange Agreements with Insurers or Employers								✓
Reduce the Medicare Contractor Error Rate			✓					✓
Improve the Medicare Provider Compliance Rate			✓					✓
Medicare Operations								
Improve Beneficiary Telephone Customer Service			✓					
Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements			✓					
Increase the Use of Electronic Commerce/Standards in Medicare			✓		✓			
Maintain CMS's Improved Rating on Financial Statements								✓
Improve CMS Oversight of Medicare Fee-for-Service Contractors					✓			✓
Increase Referral of Eligible Delinquent Debt for Cross Servicing								✓
Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries			✓		✓			
Improve Beneficiary Understanding of Basic Features of the Medicare Program			✓		✓			
Federal Administrative Costs								
Develop and Implement an IT Architecture					✓			
Develop New Medicare Payment Systems in Fee-for-Service and Medicare+Choice			✓					✓
Improve CMS's Workforce Planning								✓
Improve CMS's Management Structure								✓
Strengthen and Maintain Diversity at all Levels of CMS								✓
Increase Awareness About the Opportunity to Enroll in the Medicare Savings Programs			✓					
Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization								✓
Research, Demonstration, and Evaluation								
Assess the Relationship between CMS Research Investments and Program Improvements				✓				

APPENDIX A

FY 2004 APP Performance Goal	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
Revitalization Plan								
Improved CMS's Information Systems Security		✓						

* DHHS Strategic Goals

Goal 1 – Reduce the major threats to the health and well-being of Americans.

Goal 2 – Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges

Goal 3 – Increase the percentage of the Nation's children and adults who have access to regular health care services and expand consumer choices

Goal 4 – Enhance the capacity and productivity of the Nation's health science research enterprise

Goal 5 – Improve the quality of health care services

Goal 6 – Improve the economic and social well-being of individuals, families, and communities, especially those most in need

Goal 7 – Improve the stability and healthy development of our Nation's children and youth

Goal 8 – Achieve excellence in management practices

APPENDIX A

**Linking CMS's FY 2004 Performance Goals
to CMS's Strategic Goals***

Protect and improve beneficiary health and satisfaction. • Improve satisfaction of Medicare beneficiaries with health care services they receive. • Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal. • Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram. • Increase the percentage of Medicaid two-year-old children who are fully immunized. • Decrease the number of uninsured children by working with States to implement SCHIP & by enrolling children in Medicaid. • Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams. • Protect the health of Medicare beneficiaries by optimizing the timing of administration of antibiotics to reduce the frequency of surgical site infection. • Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP). • Decrease the prevalence of restraints in nursing homes. • Decrease the prevalence of pressure ulcers in nursing homes.
Foster appropriate and predictable payments and high quality care. • Develop new Medicare payment systems in FFS & Medicare+Choice. • Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.
Promote understanding of CMS programs among beneficiaries, the health care community, and the public. • Improve effectiveness of dissemination of Medicare information to beneficiaries • Improve Medicare's administration of the beneficiary appeals process. • Improve beneficiary understanding of basic features of the Medicare program. • Increase awareness about the opportunity to enroll in the Medicare Savings Programs.
Promote the fiscal integrity of CMS programs and be an accountable steward of public funds. • Maintain CMS's improved rating on financial statements. • Reduce the percentage of improper payments made under the Medicare fee-for-service (FFS) program. • Reduce the Medicare contractor error rate. • Improve the Medicare provider compliance rate. • Improve the effectiveness of the administration of the Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data exchange agreements with insurers or employers. • Increase referral of eligible delinquent debt for cross servicing. • Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring & ultimately reducing Medicaid payment error rates. • Assess program integrity customer service. • Improve the provider enrollment process. • Improve management of Survey & Certification budget development & execution process.
Foster excellence in the design and administration of CMS programs. • Improved beneficiary telephone customer service. • Improve CMS's oversight of Medicare fee-for-service contractors. • Develop & implement information technology architecture. • Improve CMS's information systems security. • Increase the use of electronic commerce/standards in Medicare. • Improve CMS's workforce planning. • Improve CMS's management structure. • Strengthen and maintain diversity at all levels of CMS. • Implement CMS Restructuring Plan to create a more citizen-centered organization.

APPENDIX A

Provide leadership in the broader health care marketplace to improve health.

- Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver.
- Assess the relationship between CMS research investments & program improvements.

***Please note:** A performance goal may be linked to more than one strategic goal.
Primary linkages are represented here.

APPENDIX A

A.2.a Changes In Annual Performance Plan (APP) Goals

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Medicare Benefits						
Improve satisfaction of Medicare beneficiaries with the health care services they receive. (Beginning FY 2001: the goal includes data from disenrollees.)	● ✓	● ✓	● ✓	● ✓	✓	✓
Enroll beneficiaries into managed care plans timely. FY 2002-2003: Process Medicare+Choice Organization elections in compliance with the BBA beneficiary election provisions.	○ ✓	● ✓	● ✓	○ ✓		
Improve Medicare's administration of the beneficiary appeal process.		○ ✓	Ⓟ ✓	Ⓟ ✓	✓	✓
Increase health plan choices available to Medicare beneficiaries removed in FY 2001 to focus on areas under CMS's control.	○ ✓	● ✓				
Quality of Care: Quality Improvement Organizations						
Improve heart attack survival rates.		○ ✓	Ⓛ ✓	Ⓛ ✓		
Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal. (Beginning FY 2001: lifetime pneumococcal vaccination included and data source changed from NHIS to Medicare Current Beneficiary Survey to include institutional based beneficiaries.)	● ✓	● ✓	Ⓟ ✓	Ⓛ ✓	✓	✓
Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram. (Beginning FY 2001: data source changed from NHIS to Medicare claims data to include institutional based beneficiaries.)	● ✓	● ✓	● ✓	Ⓛ ✓	✓	✓
Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.			● ✓	Ⓛ ✓	✓	✓
Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection.					✓	✓
Quality of Care: Survey & Certification						
Decrease the prevalence of restraints in nursing homes.	● ✓	● ✓	● ✓	Ⓛ ✓	✓	✓
Decrease the prevalence of pressure ulcers in nursing homes.		● ✓	○ ✓	Ⓛ ✓	✓	✓
Improve the management of the Survey and Certification budget development and execution process.			● ✓	● ✓	✓	✓
Grants to States for Medicaid/Medicaid Agencies						
Work with States to develop Medicaid program performance goals. (Beginning FY 2000 increase the percentage of Medicaid two-year old children who are fully immunized.)	● ✓	● ✓	● ✓	● ✓	✓	✓
Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries.	● ✓	● ✓	● ✓	● ✓		
Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.			○ ✓	● ✓	✓	✓
Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP).					✓	✓
Improve access to care for elderly & disabled Medicare beneficiaries who do not have public or private supplemental insurance.	● ✓	● ✓	Ⓟ ✓			

APPENDIX A

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
State Children's Health Insurance Program						
Decrease the number of uninsured children by working with States to implement SCHIP and increase enrollment of eligible children in Medicaid.	● ✓	● ✓	● ✓	● ✓	✓	✓
Clinical Laboratory Improvement Amendments (CLIA)						
Improve laboratory testing accuracy. (Beginning FY 2000 sustain improved laboratory testing accuracy.)	● ✓	● ✓	● ✓	Ⓢ ✓	✓	
Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver.						✓
Medicare Integrity Program						
Reduce the percentage of improper payments made under the Medicare fee-for-service program.	● ✓	● ✓	○ ✓	○ ✓	✓	✓
Develop and implement methods for measuring program integrity outcomes.			● ✓	Ⓢ ✓	✓	
Improve the effectiveness of program integrity activities through the successful implementation of the Comprehensive Plan for Program Integrity. Goal was completed in FY 2001.			Ⓢ ✓			
Increase Medicare Secondary Payer liability & no-fault dollar recoveries. Focus changed beginning FY 2001 to increase Medicare Secondary Payer credit balance recoveries and/or decrease recovery time. FY 2003: Improve the process of credit balance recoveries.		● ✓	● ✓	● ✓	✓	
Assess program integrity customer service.				● ✓	✓	✓
Improve the provider enrollment process.				Ⓢ ✓	✓	✓
Improve the effectiveness of the administration of Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data exchange agreements with insurers or employers.						✓
Reduce the Medicare contractor error rate.						✓
Improve the Medicare provider compliance rate.						✓
Improve the efficiency of the medical review of claims. Goal discontinued, focus change from quantity to quality.		○ ✓				
Reduce the percentage of Medicare home health services provided for which improper payment is made.	● ✓	○ ✓				
Increase the ratio of recoveries identified to audit dollars spent. (Discontinued after FY 2000 due to data source concerns.)		● ✓				
Medicare Operations						
Improve beneficiary telephone customer service.		○ ✓	● ✓	Ⓢ ✓	✓	✓
Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.		● ✓	● ✓	● ✓	✓	✓
Increase the use of electronic commerce/standards in Medicare.	● ✓	● ✓	Ⓢ ✓	● ✓	✓	✓
Maintain CMS's improved rating on financial statements.	● ✓	● ✓	● ✓	● ✓	✓	✓
Improve CMS oversight of Medicare fee-for-service contractors.			● ✓	● ✓	✓	✓

APPENDIX A

GPRA Performance Goals by Budget Category	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
Increase referral of eligible delinquent debt for cross servicing.				○	✓	✓
Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service. (In FY 2000, combined with the National Medicare & You Education Program beneficiary information goal, below.)		●	●	✓		
Improve effectiveness of dissemination of Medicare information to beneficiaries (Beginning FY 2001: fee-for-service component split as a new goal under Medicare Operations)		✓	●	●	✓	✓
Improve beneficiary understanding of basic features of the Medicare program.			●	●	✓	✓
Ensure millennium compliance (readiness) of CMS computer systems.	●	●				
Federal Administrative Costs						
Develop and implement an information technology architecture.		●	Ⓟ	●	✓	✓
Develop new Medicare payment systems in fee-for-service and Medicare+Choice.	●	✓	●	✓	✓	✓
Improve CMS's workforce planning.				✓	✓	✓
Improve CMS's management structure.					✓	✓
Strengthen and maintain diversity at all levels of CMS.					✓	✓
Increase awareness about the opportunity to enroll in the Medicare Savings Programs.				●	✓	✓
Implement CMS Restructuring Plan to create a more citizen-centered organization.					✓	✓
Ensure compliance with HIPAA requirements through the use of policy form reviews.		●	●			
Research, Demonstration, and Evaluation						
Assess the relationship between CMS research investments and program improvements.	●	Ⓟ	●	✓	✓	✓
Revitalization Plan						
Improve CMS's information systems security. (FY 2000 – FY 2003 in Federal Administrative Costs budget category)		○	Ⓟ	Ⓜ	✓	✓

- ✓ Goal in identified year
- Goal met
- Goal not met
- Ⓟ Goal partially met
- Ⓜ Final data pending

A.2.b Revised Final FY 2003 GPRA Annual Performance Plan Goals**Process Medicare+Choice Organization Elections in Compliance with the BBA Beneficiary Election Provisions MB3-03****Original FY 2003 Target**

Medicare+Choice organization (M+CO) election transactions are accepted and used to update beneficiary data timely. Target percentage to be developed based on data collected in last quarter of FY 2002.

Revised Final FY 2003 Target

Due to legislation, this goal has been discontinued.

Rationale

Due to the passage of the Bioterrorism Preparedness Act of 2001 (enacted June 2002), the implementation of the lock-in provisions has been statutorily delayed until FY 2005. Because there will be no data to report in FY 2003 and FY 2004, this goal is discontinued.

Improve Medicare's Administration of the Beneficiary Appeals Process MB4-03**Original FY 2003 Target:** Developmental.

M+CO: Begin collecting data to establish baseline.

FFS: A pilot program is under consideration to analyze FFS appeal data already collected from fiscal intermediaries and carriers.

Revised Final FY 2003 Target

Developmental.

M+CO: Enhance data collection at the Independent Review Entity (IRE) level.

FFS: Developmental.

Rationale

This data collection will eliminate any additional reporting burdens on the M+COs. The Benefits Improvement and Protection Act (BIPA) of 2000 mandated a new appeals process, which will change the requirements for FFS data collection.

Improve Heart Attack Survival Rates By Decreasing Mortality QIO1-03**Original FY 2003 Target**

To decrease the 1-year mortality rate to 27.4 percent among Medicare beneficiaries following hospital admissions for heart attack.

Revised Final FY 2003 Target

This goal has been discontinued.

APPENDIX A

Rationale

There are a number of interventions that have proven to be successful for increasing heart attack survival following a heart attack, and we have made use of these interventions in hospitals. However, recent data indicate that the number of deaths occurring within one year following hospitalization for heart attack is not decreasing. Many complex variables might have made significant independent contributions to the survival rate. We will continue to report our results through FY 2002 but we are discontinuing this goal beginning in FY 2003. The CMS will continue to encourage and monitor research in this area to determine what may be causing these disappointing trends.

**Protect the Health of Medicare Beneficiaries Age 65 Years and Older by
Increasing the Percentage of Those Who Receive an Annual Vaccination for
Influenza and a Lifetime Vaccination for Pneumococcal QIO2-03**

Original FY 2003 Target (Pneumococcal)

To achieve a 69 percent lifetime pneumococcal vaccination rate among Medicare beneficiaries age 65 years and older.

Revised Final FY 2003 Target (Pneumococcal)

To achieve a 67 percent lifetime pneumococcal vaccination rate among Medicare beneficiaries age 65 years and older.

Rationale

Most recent MCBS data indicate that the rate for pneumococcal vaccinations is slowing down from what has been seen in recent years. In light of this information, we are revising our FY 2003 target to a more realistic target of achieving a 67 percent lifetime pneumococcal vaccination rate in Medicare beneficiaries age 65 years and older. The CMS will continue to actively promote the receipt of lifetime pneumococcal vaccinations, and we will continue monitoring trends.

**Improve Early Detection of Breast Cancer Among Medicare Beneficiaries
Age 65 Years and Older by Increasing the Percentage of Women
Who Receive a Mammogram QIO3-03**

Original Baseline

45 percent of female FFS Medicare beneficiaries age 65 years and older received a mammogram within a two-year period (1997-1998 National Claims History File data).

Revised Baseline

51 percent of female FFS Medicare beneficiaries age 65 years and older received a mammogram within a two-year period (2000-2001 National Claims History File data).

APPENDIX A

Original FY 2003 Target

To increase to 53 percent Medicare beneficiaries age 65 years and older who will have received a mammogram in a two-year period (National Claims History File).

Revised Final FY 2003 Target

To increase to 51.5 percent Medicare beneficiaries age 65 years and older who will have received a mammogram in a two-year period (National Claims History File).

Rationale

The baseline and target have been revised to attain consistency with the 2002 HEDIS® measure and to reflect changes in billing codes for digital mammograms, conversion of film to digital images, and for computer-aided screening. Additionally, trends indicate diminished gains in the biennial mammography rate among women age 65 and older from 1997-98 to 2000-01.

Protect the Health of Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection QIO5-03**New FY 2003 Goal**

The goal to protect the health of beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection is a component of the Surgical Site Infection Prevention (SIP) Project, which is currently being implemented by our QIOs. The focus of this goal is to decrease the complications from infection following a surgical procedure by increasing the rate by which antibiotics are administered in the recommended timeframe. By doing this we will be able to improve the health care outcomes for our beneficiaries, while decreasing the morbidity and mortality, and overall health care costs.

Rationale

This goal has been added to the performance plan in order to incorporate the new initiatives included in the Seventh Scope of Work as well as the initiative on preventive health.

Improve the Management of the Survey and Certification Budget Development and Execution Process QSC-03**Original FY 2003 Target**

Allocate FY 2003 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care and non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.

APPENDIX A

Revised Final FY 2003 Target

Allocate FY 2003 State Survey and Certification budget using the price-based budget methodology to distribute, at a minimum, any budget increases to those States that do not exceed 15 percent above the combined national average hours for long term care and/or non long term care surveys. Use performance measures and associated baselines to measure the quality of the survey work performed.

Rationale

We remain committed to analyzing average hours for both long term care and non-long term care surveys as part of the budget methodology. However, due to the uncertainty of the appropriations process and future resource challenges facing State survey agencies, CMS is unsure about the feasibility of this approach and its impact on State survey agencies. Therefore, and if necessary, we have decided to allow the flexibility to continue our current focus on long term care survey hours only.

Assist States in Conducting Medicaid Payment Accuracy Studies for the Purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates MMA4-03**Original FY 2003 Target**

Expand the PAM Program to fifteen States. Pilot test the CMS PAM Model with ten of these States; pilot test innovative alternative payment accuracy methodologies with five States. Assess the FY 2002 nine State experiences and review final reports; collaborate with the States, The Lewin Group, and others in CMS and OIG to finalize specifications for the CMS PAM Model.

Revised Final FY 2003 Target

Expand the Medicaid PAM Project to **twelve States. Pilot test the CMS PAM Model in all twelve of these States.** Assess the FY 2002 nine State experiences and review final reports; collaborate with the States, The Lewin Group, and others in CMS and OIG to develop draft final specifications for the CMS PAM Model.

Rationale

The target for this goal has been changed to reflect the actual number of States that will participate in the Medicaid PAM Project during FY 2003. Twelve proposals were received from States in response to the all State solicitation sent to State Medicaid Directors, May 7, 2002; all twelve of the States that have applied to participate in the PAM Project during FY 2003 will be awarded PAM Project grants. As such, the program will expand from nine States in FY 2002 to twelve States during FY 2003. All twelve States will pilot test the CMS PAM Model. CMS will not pilot test alternative payment accuracy methodologies in FY 2003.

APPENDIX A

Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP) MMA5-03**Original FY 2003 Title**

Improve Health Care Quality Across the Medicaid and State Children's Health Insurance Program (SCHIP) Through the CMS/State Performance Measurement Partnership Project (PMPP)

Revised FY 2003 Title

Improve Health Care Quality Across the Medicaid and State Children's Health Insurance Program (SCHIP)

Rationale (for revised title)

CMS is revising the title of this goal to be more inclusive of the all of the Medicaid and SCHIP activities to improve health care quality.

Original FY 2003 Target

To begin working with States on the Performance Measurement Partnership Project (PMPP).

-- Medicaid

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; and (b) Initiate action steps for implementing recommendations.

-- SCHIP

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; (b) Initiate action steps for implementing recommendations; and (c) Begin to implement core SCHIP performance measures.

Revised FY 2003 Target

To begin working with States on the Performance Measurement Partnership Project (PMPP).

-- Medicaid

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; (b) **Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement;** and (c) Initiate action steps for implementing recommendations.

-- SCHIP

(a) Report on results of the meeting with State representatives and identify a timeline for implementing recommendations; (b) **Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement;** (c) Initiate action steps for implementing recommendations; and (d) Begin to implement core SCHIP performance measures.

APPENDIX A

Rationale (for revised target)

We are adding this milestone to our target to include all of the major steps that CMS and the States are taking toward reaching a measurable goal.

Decrease the Number of Uninsured Children by Working with States to Implement SCHIP and by Enrolling Children in Medicaid SCHIP1-03**Original FY 2003 Target**

To be determined. Currently, we are in the process of re-evaluating the goal and anticipate releasing a revised goal in early FY 2002.

Revised Final FY 2003 Target

Increase the number of children who are enrolled in regular Medicaid or SCHIP by five percent over the previous year.

Rationale

When The State Children's Health Insurance Program began in 1997, CMS implemented an enrollment goal to enroll five million children in the program by FY 2005. Because we have exceeded this goal and are now seeing States face fiscal challenges that may affect program outreach and enrollment, we are less sure about future projections and have decided to set our FYs 2003 and 2004 targets to increase enrollment by five percent over the previous year.

Improve the Process of Credit Balance Recoveries MIP5-03**Original FY 2003 Goal Title**

Increase Medicare Secondary Payer (MSP) Credit Balance Recoveries and/or Decrease Recovery Time to Recoup Dollar Recoveries

Revised FY 2003 Goal Title

Improve the Process of Credit Balance Recoveries

Rationale

The title for this goal has been revised to more accurately reflect the activity.

Improve Beneficiary Telephone Customer Service MO1-03**Original Baseline**

Developmental. Baseline data on accessibility, accuracy of response, and caller satisfaction are being collected and will be available by the end of FY 2002.

APPENDIX A

Revised Final Baseline

National quality targets defined. Currently no standardization of telephone call centers; one pilot underway.

Original FY 2003 Target

Using baseline data, establish call center performance targets for accessibility, accuracy of response, and caller satisfaction. Collect monthly data from each call center and compare performance against targets, identify where improvements are needed on national and regional levels. Take necessary actions and/or conduct training to bring about improved performance. Specific target goals to be determined.

Revised Final FY 2003 Target**(1) Quality Standards:**

- Minimum of 85 percent pass rate for Adherence to Privacy Act
- Minimum of 90 percent meets expectations for Customer Skills Assessment
- Minimum of 85 percent meets expectations for Knowledge Skills Assessment

(2) Begin national expansion of 1-800-MEDICARE**Rationale**

A shift in Agency priorities and the strategy for telephone customer service required a redirection of funding for the national caller satisfaction survey to a pilot operation in Pennsylvania (beneficiaries calling a single 800 number) in early FY 2002. The CMS also made the development and implementation of a standard desktop for customer service representatives at contractor call centers one of its highest priorities for telephone delivery. This shift towards the national expansion of 1-800-MEDICARE as the single beneficiary inquiry line reflects a significant systems change that will improve responsiveness to our beneficiaries. Given the lack of baseline data and the change in Agency priorities, the caller satisfaction and accessibility measures have been discontinued at this time.

Improve CMS Oversight of Medicare Fee-for-Service Contractors MO5-03**Original FY 2003 Target**

Developmental.

Revised Final FY 2003 Target

Building on program achievement in prior years, CMS will move further toward its goal of national uniform contractor evaluation.

Rationale

This is a developmental goal following a timeline to reach a national uniform contractor evaluation.

**Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries
through the National Medicare & You Education Program (NMEP) MO8-03**

Original FY 2003 Title

Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries through the National Medicare & You Education Program (NMEP)

Revised Final FY 2003 Title

Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries

Rationale

The reference to NMEP was removed from the title so as not to limit the focus of this goal. While NMEP efforts will have an impact on beneficiary behavior affecting the outcome of this goal, the NMEP alone does not control whether or not we meet our targets. In addition, there are other pertinent activities outside of NMEP which can contribute to the outcome of this goal.

**Improve Beneficiary Understanding of Basic
Features of the Medicare Program MO9-03**

Original Baseline

Developmental.

Revised Final Baseline

- (1) Beneficiaries were able to answer correctly 2.75 questions out of 6 questions measuring beneficiary understanding of different components of the Medicare program.
- (2) Fifty-three percent of Medicare beneficiaries were aware that Medicare has a 1-800 information number.

Original FY 2003 Target

Developmental.

Revised Final FY 2003 Target

Continue collecting and monitoring the Medicare Current Beneficiary Survey (MCBS) data on (1) & (2) above for reporting on FY 2004 targets.

Rationale

The FY 2002 goal was to develop baselines/targets to:

- improve awareness of the core features of Medicare that beneficiaries need to know to use the program effectively, and
- improve beneficiary awareness of CMS sources from which additional information can be obtained if needed.

The baselines and targets are shown above.

APPENDIX A

Develop and Implement an Information Technology Architecture FAC2-03**Original FY 2003 Target**

Continue maturing the ITA, including further expansion of both breadth and depth, as opportunities and needs arise. Develop architectural support services for enterprise-wide use, for example, business modeling or technology assessment. Implement IT policies and procedures, and continue additional IT policy and procedure development for needed subject areas.

Revised Final FY 2003 Target

Continue to develop the ITA (Enterprise Architecture), including further expansion of both breadth and depth using a segmented approach, with specific segments determined as opportunities and needs arise. Complete development and promulgation of remaining IT policies.

Rationale

Goal is moving forward and implementation of policy and procedures has and will continue to occur.

Increase CMS's Information Systems Security FAC3-03***Original FY 2003 Target**

Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Implement improved access control management system. Conduct penetration testing and vulnerability assessments at a subset of Medicare contractors and CMS service providers. Include systems security reviews in Contractor Performance Evaluations (CPEs).

Revised Final FY 2003 Target

Achieve zero material weaknesses in the EDP portion of the FY 2002 CFO audits. Implement improved access control management system.

Rationale

The major emphasis of this goal is to close the security gaps at the contractor level. All available resources are being used to fund implementation of the security safeguards necessary to comply with CMS's baseline security requirements.

*See new FY 2004 Revitalization Plan budget category for more information.

Improve CMS's Workforce Planning FAC6-03**Original Baseline**

Developmental. Baseline data to determine skill and knowledge gaps will be available from the workforce planning automated system in FY 2003.

Revised Final Baseline

Developmental. Baseline data to determine skill and knowledge gaps will be available from the workforce planning automated system in FY 2004.

Original FY 2003 Target

Fully implement automated workforce planning system, including updating previously collected data and establishing a knowledge and skill level baseline.

Revised FY 2003 Target

Complete development of and implement automated workforce planning modules.

Rationale

During FY 2002, a prototype system was developed. After evaluating the initial prototype, CMS decided to develop a series of automated workforce planning modules linked to our human resource information system, rather than build a "stand-alone" workforce planning system. Completion of these modules is expected in FY 2003. Full implementation, in FY 2004, will give CMS data on knowledge and skill gaps that can be tracked over time.

Improve CMS's Management Structure FAC7-03**Original FY 2003 Target**

(a) Performance Management: Full implementation of a competency-based performance management system for non-Senior Executive Service (non-SES) managers; (b) Awards and Recognition: Implementation of an awards and recognition program for non-SES managers directly linked to managerial effectiveness and program results; and (c) Explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of LMDS activities.

Revised FY 2003 Target

(a) Performance Management: Full implementation of a competency-based performance management (**planning and appraisal**) program for non-Senior Executive Service (non-SES) managers; (b) Awards and Recognition: Implementation of an awards and recognition program for non-SES managers directly linked to managerial effectiveness and program results; and (c) Explore data sources to develop a baseline and targets for measuring the progress of the activities and/or the improvement in management competency as a result of LMDS activities.

Rationale

We are revising the target language to clarify that the Performance Management System is a planning and appraisal program for non-SES managers.

APPENDIX A

Increase Awareness of the Opportunity to Enroll in the Medicare Savings Programs FAC9-03**Original FY 2003 Target**

To be determined. We will increase awareness of Medicare Savings Programs and set target based on FY 2002 baseline.

Revised FY 2003 Target

Increase awareness of Medicare Savings Programs to 13 percent.

Rationale

We are revising the target language because the FY 2002 baseline has been established and future targets have been developed.

Assess the Relationship between CMS Research Investments and Program Improvements R1-03**Original FY 2003 Target**

Repeat internal and external assessments.

Revised FY 2003 Target

Conduct internal assessment.

Rationale

Based on the recommendations made by the external reviewers and CMS research leadership, we plan to continue annual internal assessments and to further integrate them with our work planning and budgeting processes. However, since research agendas and findings are usually part of an ongoing multiyear process, we believe it will be more effective to perform external reviews every 3 years. We will conduct our next external assessment in FY 2005.

A.3 Partnerships and Coordination

The CMS accomplishes its mission by working closely with many other organizations. This includes working relationships with CMS agents (Medicare contractors, State Medicaid Agency staff, State surveyors, and Quality Improvement Organizations, providers of care (hospitals, physicians, health plans, clinical laboratories, etc.), beneficiary and consumer organizations, accrediting bodies (the Joint Commission on Accreditation of Healthcare Organizations and the National Committee on Quality Assurance), and researchers who work together to ensure high quality care for nearly 82 million Medicare and Medicaid beneficiaries.

The CMS continues to increase coordination with States in the performance plan process. State Medicaid agencies are directly involved in carrying out the goals for decreasing the number of uninsured children; assisting States in conducting Medicaid

APPENDIX A

payment accuracy studies, linking Medicare and Medicaid data; and increasing rates of immunization for Medicaid children.

The CMS works closely with a number of other Federal agencies, both within and outside HHS, on special programs and crosscutting issues. For example:

- The CMS depends on assistance from the Centers for Disease Control and Prevention (CDC) in our efforts to increase influenza and pneumococcal vaccination rates.
- The CMS, the HHS Inspector General, the FBI, and the Administration on Aging work together to reduce fraud, waste, and abuse.
- The CMS, the Health Resources and Services Administration (HRSA), and other HHS agencies (e.g., CDC and Agency for Healthcare Research and Quality) are working together to improve children's access to health care services.
- The CMS and the CDC are providing ongoing technical assistance to States as they explore methodologies and develop baselines for measuring the number of Medicaid two-year olds who are fully immunized.

Working in partnership leverages resources and increases coordination, which is ultimately in the beneficiaries' best interest. Each performance goal narrative includes a coordination section.

A.4 Data Issues – Data Verification and Validation

The CMS uses many data systems to measure its performance on GPRA goals. Each goal in the APP contains a section on data verification and validation and describes any limitations of the data sources. Relying on a number of administrative and survey data systems presents certain difficulties and vulnerabilities. For example, there are inherent time lags between the actual data submission, data compilation, and the due dates for report submissions. Goals for which data are not yet available will be included in a subsequent Annual Performance Report.

The CMS conducts comparisons across similar data systems where practical to ensure validity and reliability of data sources. For example, under performance goal MB1-04 (a goal to improve Medicare beneficiary satisfaction with services), the Medicare Consumer Assessment of Health Plans Study (CAHPS) is used to assess beneficiary satisfaction with health plans. We will check the consistency of CAHPS data with similar data from the Medicare Current Beneficiary Survey. Another approach we employ to ensure data quality is the use of consistency edits. For example, the On-line Survey and Certification and Reporting (OSCAR) data system (used to measure the prevalence of restraints in nursing homes) measures State-to-State and facility-to-facility variation within data elements. Our experience has shown that these variations have been relatively constant, resulting in national measurements with high reliability.

APPENDIX A

In addition to data already available through CMS systems, CMS's APP relies on survey data, evaluations, and special studies conducted by other Federal agencies. The CMS relies on these agencies to verify and validate their data. External data sources enable us to conserve resources by minimizing duplication of effort. Since most of these surveys, studies, and audits are conducted for multiple purposes, refinements of methods and definitions that strengthen data collection for one purpose may weaken the usefulness of the information of CMS's performance measurement under GPRA. If a data source changes in a manner that diminishes its appropriateness for our performance measure or a better data source is identified, we will evaluate our approach. For instance, in our mammography goal, we are now using Medicare claims data since the National Health Interview Survey did not include institutional-based beneficiaries.

One of the biggest challenges that we face in the analysis of performance data is timeliness. In some cases, there are inherent time lags between the actual data submission, data compilation, and the due dates for report submission.

A.5 Performance Measurement Linkages with Budget, Cost Accounting, Information Technology Planning, Capital Planning, and Program Evaluation

Linking Performance Measurement to the CMS Budget

We have taken care to ensure that major budget categories, including both program benefits and program administration funds, have adequate coverage in the APP. Our performance plan and report are organized by budget category to provide a linkage of performance goals, program activities and dollar amounts. These linkages ensure that in setting performance goals, CMS selects goals that are representative of the full range of Agency activities and resources.

Linking Performance Measurement to Cost Accounting

We select the performance goals in CMS's APP based on the fact that, collectively, they broadly represent the work of the Agency. Where appropriate, explicit cost linkages exist. In other cases explicit cost linkages are not made, but activities are linked to budget categories as explained above. The CFO clean opinion goal shows our commitment to clear and complete accounting for funds across the Agency.

Linking Performance Measurement to Information Technology (IT) and Capital Planning

Capital investment, primarily in the form of technology, supports all of CMS's goals. The CMS technology investments are funded through the Agency's annual Information Technology (IT) budget, which in turn is funded from several of CMS's accounts.

We have continued to include information technology planning in the FY 2004 APP in our goal to develop and implement an information technology architecture, as required by the Clinger-Cohen Act of 1996 and in alignment with CMS's strategic business

objectives. We believe implementation of the full process must be phased to be fully successful, and our performance goal reflects that approach.

Performance Measurement Linkages with Program Evaluation

The CMS performs, coordinates, and supports research and demonstration projects (through studies, contracts, grants, and waivers) to develop and implement new health care financing policies and to evaluate the impact of CMS's programs on beneficiaries, providers, States, Tribes, and other customers and partners. The scope of CMS's research, demonstration, and evaluation activities embrace all areas of health care relevant to CMS programs: costs, access, quality, service delivery models, and financing approaches.

The CMS has planned several program and demonstration evaluations over the next five years and beyond to assess our strategies for improving our programs. Findings from our demonstration evaluations will be used to help CMS plan for the future of our programs and modify strategies for accomplishing our APP and strategic goals. We have included in our APPs a performance goal, which directly assesses our research and demonstration activities.

We consider the evaluation work of others, such as the Office of Inspector General, the General Accounting Office, and the Medicare Payment Advisory Commission, in developing our performance plan. Findings from evaluation by these entities have influenced our choice of performance measures, including the Medicare fee-for-service error rate goal and our goal to stratify the Medicare payment error rate to strengthen our ability to target problem areas.

The CMS strongly emphasizes its priorities in its performance plans. Going into our fourth year of reporting, the process is already having an effect on the management of our programs as indicated in the reports. Reporting over time will reveal trends, which will increase the usefulness of the GPRA process in the management of CMS's programs.

APPENDIX A

A.6 Developmental Goals Timeline

Some of our goals are labeled “developmental” goals. We include these goals in our plan to show our commitment to certain priorities while acknowledging the challenges of developing a specific, measurable goal.

Improve Medicare’s Administration of the Beneficiary Appeal Process (MB4-04)**FY 2000**

- Implement system for collecting appeals data from Medicare+Choice Organizations (M+CO) (was indefinitely delayed due to additional burden).

FY 2001

- OPL published April 27, 2001.

FY 2002

- Issued OPL with reporting instructions for M+COs.
- Evaluated CMS’s FFS appeal data needs and capabilities.

FY 2003

- Enhance data collection at the Independent Review Entity (IRE) level for M+COs.

Improve Health Care Quality Across Medicaid and the State Children’s Health Insurance Program (MMA5-04)**FY 2003**

- The CMS and States will identify a strategy for improving health care delivery and/or quality and specify the measures for gauging improvement.
- Develop timeline for implementing the strategy identified by CMS and States.
- Develop data submission, methodological, and reporting processes.
- 2002 data will be collected from States (testing phase).

FY 2004

- Data submission, methodological processes, and reporting will be refined.
- Produce 2002 performance measures in standardized reporting format (testing phase).
- 2003 data (baseline) will be collected from States.

FY 2005

- Reporting of 2002 and 2003 performance measures in standardized reporting format.
- 2004 data will be collected from States.
- Implementation of the targeted quality improvement programs will commence.

APPENDIX A

FY 2006

- Reporting of 2002 (testing), 2003 (baseline) and 2004 performance measures in standardized reporting format
- Re-measurement will occur with 2005 data.
- New quality improvement cycle begins.

FY 2007

Evaluation and Final Report.

Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver (CLIA2-04)

FY 2003

- Developing educational materials and resources for laboratories.
- Continue to conduct surveys of laboratories holding a certificate of waiver on a nationwide scale.
- Collecting baseline data on which to measure improvement and setting future targets.

FY 2004

- Continue to conduct surveys of laboratories holding a certificate of waiver on a nationwide scale, including referral of laboratories to the educational materials and resources developed in FY 2003.
- Re-assess the need for continuation of this project into FY 2005 and beyond.
- Assess the other opportunities available to further ensure that laboratories performing waived tests can improve and sustain testing accuracy.

Improve CMS Oversight of Medicare Fee-For-Service Contractors (MO5-04)

FY 2001

- Evaluated and further refined the risk analysis methodology.
- Evaluated, further improved and continued to develop national review protocols.
- Developed a comprehensive set of clear and measurable contractor performance standards.
- Completed development of and implemented a national CPE database to provide management information on the progress of CPE 2001.
- Performing pre-issuance quality assessment of review reports to ensure greater consistency.
- Started reviews in the first quarter of FY 2001.
- Conducted a national Lessons Learned Conference for over 150 reviewers.
- Performed pre-issuance quality assessment of review reports to ensure greater consistency.
- Completed and issued rewrite of CPE portion of the Regional Office Manual.
- Issued eleven CPEXtras providing real time CPE operational policy guidance.
- Implemented a contractor rebuttal process.

APPENDIX A

- Began development of a training curriculum for CPE reviewers.
- Provided feedback on performance by business function to Central Office program managers.
- Issued 37 annual FY 2000 Reports of Contractor Performance to the CEO's of each corporation serving as a Medicare contractor.

FY 2002

- Again used FY 2001 CPE Risk Assessment Matrix to ensure any contractor not previously selected in our 3-year cyclical approach for on-site CPE business function reviews is evaluated by the end of FY 2003.
- Evaluated national review protocols with the goal of further improvement and consistency in format and terminology.
- Developed plan and timeline for issuance to contractor executives of FY 2002 Reports of Contractor Performance.
- Made further enhancements to the CPE national database in the fourth quarter of FY 2002.
- Identified issues to raise and clarifications to make during FY 2003 Lessons Learned Conference by conducting reviews of FY 2002 work papers on a limited number of reviews.
- Submitted for Clearance to the Department the Federal Register notice of Criteria and Standards for Evaluating the Contractors in FY 2003.

FY 2003

- Planning further improvement to national review protocols.
- Are again selecting regional office managers to serve as Project Leaders for teams evaluating a specific business function.
- Will conduct national Lessons Learned Conferences.
- Will conduct training of all CPE reviewers on each of the protocols, videotape the training and provided copies to each of the regional offices.
- Continue to enhance the CPE national database as needed.
- Planning to keep a core of RO-CO review team members together (where feasible) on all reviews they conduct.
- Planning to continue to conduct pre-issuance quality assessment of review reports to ensure greater consistency.
- CPE requires close coordination with other CMS components that are responsible for the various business functions handled by fee-for-service contractors. The Office of Financial Management (OFM) has responsibility for the payment safeguard and financial business functions. OFM plans to contract in FY 2003 with independent audit firms to conduct SAS-70 reviews of contractors in the various business functions for which it has responsibility. These SAS-70s are to be used in place of conducting CPE evaluations. We will coordinate with OFM and determine a means to incorporate those findings into the overall performance picture we supply to contractor executives sometime after the close of the fiscal year.
- There will be fewer CPE reviews conducted in FY 2003 by CMS reviewers compared to FY 2002. Most CMS reviews will be in business functions such as

APPENDIX A

customer service, appeals, claims processing, provider enrollment and reimbursement. Reviews of other functions will be conducted by SAS-70s

Improve CMS's Workforce Planning (FAC6-04)**FY 2000**

- The CMS developed a competency catalogue of skills and knowledge required to accomplish Agency functions.

FY 2001

- Using this catalogue, CMS inventoried current employee competencies.
- We intended to determine baselines and targets for FY 2002 using the inventory data. However, the inventory was too cumbersome to ask staff to complete in the same format in the future. Instead, CMS:
 - Identified several specific gaps critical to meeting strategic goals.
 - Began actions to increase skills in these areas – via recruitment, development, and/or redeployment.
 - Initiated design of a dynamic, Intranet-based system to house workforce planning data.

FY 2002

- The CMS built an initial prototype for an Intranet-based system to house and track workforce planning data. Based on the prototype, CMS decided to build a series of Agency-specific workforce planning modules linked to the CMS Human Resource Information System, rather than a “stand-alone” workforce planning system.
- The CMS monitored and evaluated actions taken to increase targeted skill areas.
- The CMS determined future knowledge and skill requirements.
- The CMS defined work roles and assigned each position in the agency to a primary work role.

FY 2003

- The CMS will test the logic for a series of automated workforce planning modules.
- The CMS will build, test, and populate automated workforce planning system modules.
- The CMS will continue to monitor and evaluate actions taken to increase targeted skill areas.

FY 2004

- The CMS will fully implement a series of automated workforce planning modules, including updating data collected in FY 2000 through 2002.
- The CMS will determine baselines and targets for FY 2005.

APPENDIX A

Implement CMS Restructuring Plan to Create a More Citizen-Centered Organization (FAC10-04)**FY 2003**

- Pending additional Administration guidance, further restructuring activities for FY 2004 will be targeted.

Appendix B

State Methodologies and Reporting for the GPRA Medicaid Childhood Immunization Goal (MMA2-03)

Due to the various data collection and reporting methodologies used by individual States, immunization coverage levels are not directly comparable across States. Each State will measure its own progress, using a consistent measurement methodology.

The following Appendix summarizes State-specific methodologies and includes relevant definitions and presents each State's baseline and three-year targets for increasing childhood immunization rates.

Group I States

Although all Group I States have actively participated, there have been problems and barriers that have delayed reporting. Fifteen of the 16 Group I States have reported their first re-measurement rate. California is the only outstanding state. California lost funding for the chart review method of collecting the data used for the baseline measure and must rely on HEDIS® and National Immunization Survey (NIS) data for its reporting. This report will be forthcoming as soon as NIS results for 2002 are released from CDC at which time California intends to report its first re-measurement.

Twelve of 16 States have reported their second re-measurement rate. Idaho experienced delays early in the project as a result of their governor's initiative. Kansas is delayed due to problems in data collection and staff turnover early in the project.

Group II States

Group II States actively participated in the project, but also experienced delays. All Group II States submitted their state-specific methodologies, baseline and three-year target rates.

Five of 10 Group II States have reported their first re-measurement rate. Delaware, District of Columbia and Florida are expected to report by the end of 2002. Alaska has had trouble getting the information by their timeline due to government reorganization and moving of offices to another city. New Hampshire has had some frustration in obtaining the data according to the methodology and has hired new contractors to move this project back on schedule.

Group III States

The third and final group of this project have prepared their baseline methodologies, but have also experienced delays with several States requesting extensions. Seventeen of the 24 Group III States have reported their baselines and most of those 16 have also

established targets. Georgia asked for an extension due to difficulty verifying the data. Illinois had some data issues to resolve and plans to report in early 2003. Indiana has had numerous staff turnover and has asked for an extension to determine the rate. New Mexico needed to change their methodology and requested an extension of the report deadline. Pennsylvania, New York, and Vermont ran into some problems obtaining a final rate for their baselines. Texas determined the NIS to be the source of their rate and must wait for CDC to release the rates. All States indicated they plan to be up to date in 2003.

Appendix B
Baseline Measurement Methodologies for the
GPRA Medicaid Childhood Immunization Goal

Group I States:

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Arizona	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(a, b, c)	FY 1999	75%	78%	78%	2003	80%
Arkansas	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(b, c)	7/1/97 – 6/30/98	65%	74%	67%	2003	90%
California	MCP & FFS 2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(d)	4 (c)	CY 1998	54%	Pending	Pending	2003	65%
Connecticut	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(a)	CY 1998	77%	75%	76%	2003	80%
Idaho	2-year old 1(b) Medicaid enrollment 2(b) Fully immunized 3(a)	4(c, d)	1/1/01 sample selection date	66%	65%	Pending	2003	76%
Iowa	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(b)	4(b, c)	CY 1998	58%	68%	68%	2003	90%
Kansas	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(a)	4(c)	FY 2000	42%	50%	Pending	2003	90%
Maine	2-year old 1(a) Medicaid enrollment 2(d) Fully immunized 3(i)	4(c, a)	7/1/98 – 6/30/99	24%	32%	2002	2003	70%
Massachusetts	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(i)	4(b)	CY 1997	64%	69%	69%	2003	80%

State	Baseline Definitions	Data Sources	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Michigan	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(k)	4(b)	CY 1997	49%	57%	65%	2003	90%
Mississippi	2-year old 1(b) Medicaid enrollment 2(d) Fully immunized 3(a)	4(a, d)	7/97 - 6/98	85%	85%	88%	2003	85%
Oklahoma	2-year old 1(a) Medicaid enrollment 2(d) Fully immunized 3(d)	4(a, b, d)	CY 1998	65%	76%	68%	2003	90%
Oregon	2-year old 1(a) Medicaid enrollment 2(e) Fully immunized 3(a)	4(a, b)	CY 1998	63%	67%	70%	8/03	67%
Rhode Island	2-year old 1(b) Medicaid enrollment 2(d) Fully immunized 3(k)	4(a, c, d)	CY 1998	75%	72%	67%	2003	79%
Utah	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(f)	4(a, b, c)	FY 1999	19%	27%	31%	2003	65%
Washington	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(d)	4(b)	CY 1998	58%	77%	80%	2003	58%

Group II States:

State	Baseline Definitions	Data Source/s	Period Covered by Baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Alaska	2-year old 1(b) Medicaid enrollment 2(p) Fully immunized 3(f)	4(c, e, d)	7/1/99 - 6/30/00	85%	Pending	2003	2004	88%
Colorado	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(f)	4(c)	CY 2000	48%	44%	2003	2004	52%
Delaware	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(f)	4(a, c)	CY 1998	43%	2002	2003	2004	60%
District of Columbia	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(f)	4(a, c)	CY 1998	50%	2002	2003	2004	72%
Florida	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(f)	4(d)	01/98	82%	2002	2003	2004	90%
Louisiana	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(c)	4(b)	CY 1998	82%	82%	2003	2004	84%
New Hampshire	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(f)	4(b, c, d)	CY 2000	67%	Pending	2003	2004	90%
North Carolina	2-year old 1(a) Medicaid enrollment 2(a) Fully immunized 3(e)	4(c)	CY 2000	34%	42%	2003	2004	60%
North Dakota	2-year old 1(a) Medicaid enrollment 2(c) Fully immunized 3(f)	4(a, c)	CY 2000	43%	45%	2003	2004	90%
South Dakota	2-year old 1(b) Medicaid enrollment 2(a) Fully immunized 3(e)	4(a)	9/30/01	52%	62%	2003	2004	90%

Group III State	Baseline Definitions	Data source/s	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Alabama	2-yr Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(a)	7/1/01 - 6/30/02	75%	2003	2004	2005	80%
Georgia	2-yr Old 1(b) Medicaid Enrollment 2(d) Fully Immunized 3(f)	4(d)	201 - 202	Pending	2003	2004	2005	pending
Hawaii	2-yr. Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(e)	4(c)	7/1/01 - 6/30/02	74%	2003	2004	2005	pending
Illinois	2-yr. Old 1(b) Medicaid Enrollment 2(a) (b) (c) Fully Immunized 3(f)	4(a, c)	Jan. 02	Pending	2003	2004	2005	pending
Indiana	2-yr. Old 1(a) & 1(b) Medicaid Enrollment 2(d) Fully Immunized 3(e) & 3(f)	4(b, c)	CY 2000	8%	2003	2004	2005	57%
Maryland	2-yr. Old 1(b) Medicaid Enrollment 2(a) Fully Immunized 3(e)	4(a, b, c)	CY 2001	52%	2003	2004	2005	56%
Minnesota	2-yr. Old 1(a) Medicaid Enrollment 2(f) Fully Immunized 3(e)	4(c)	CY 2000	11%	2003	2004	2005	20%
Missouri	2-yr. Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(c)	CY 2001	47%	2003	2004	2005	53%
Montana	2-yr. Old 1(b) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(a, b, c, d)	CY 2001	81%	2003	2004	2005	pending
Nebraska	2-yr. Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(a, c)	CY2001	44%	2003	2004	2005	70%

Group III State	Baseline Definitions	Data sources	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Nevada	2 yr. Old 1(b) Medicaid Enrollment 2(c) Fully Immunized 3(a)	4(c, d)	FY 2001	66%	2003	2004	2005	80%
New Jersey	2 yr. Old 1(c) Medicaid Enrollment 2(c) Fully Immunized 3(f), (g)	4(c)	CY 1999	44%	45%	2004	2005	60%
New Mexico	2 yr. Old 1(a) Medicaid Enrollment 2(a) Fully Immunized 3(f)	4(c)	CY 2001	pending	2003	2004	2005	pending
New York	2 yr. Old 1(a) Medicaid Enrollment 2(f), (a) Fully Immunized 3(c)	FFS - 4(c, b) MCO - 4(b, c)	Born Oct 1, 1998 - Dec 31, 1998	pending	2003	2004	2005	pending
Ohio	2 yr. Old 1(a) Medicaid Enrollment 2(c) Fully Immunized 3(g)	4 (a, c, b, d)	SFY 2001	49%	2003	2004	2005	pending
Pennsylvania	2 yr. Old 1(c) Medicaid Enrollment -2(c) Fully Immunized 3(b)	4(a, c)	7/1/98 - 6/30/99	pending	2003	2004	2005	pending
South Carolina	2 yr. Old 1(k) Medicaid Enrollment 2 (c) Fully Immunized 3 (f)	4 (a, b, c, d)	CY2000	84%	2003	2004	2005	pending
Tennessee	2 yr. Old 1(a) Medicaid Enrollment 2(d) Fully Immunized 3(a & g)	4(a, b, d)	Jan 1, 2002	60%	2003	2004	2005	80%
Texas	2 yr. Old 1(f) Medicaid Enrollment 2(b) Fully Immunized 3(a)	4(c)	7/01 - 6/02	pending	2003	2004	2005	pending
Vermont	2 yr. Old 1(b) Medicaid Enrollment 2(b) Fully Immunized 3(m)	4(b, c)	6/02	pending	2003	2004	2005	pending

Group III State	Baseline Definitions	Data source/s	Period covered by baseline	Baseline Rate	First Re-measure	Second Re-measure	Third Re-measure	Target Rate
Virginia	2 yr. Old 1(a) Medicaid Enrollment 2(c) Fully Immunized 3(a)	4(b)	7/99 – 6/00	69%	2003	2004	2005	85%
West Virginia	2 yr. Old 1(a) Medicaid Enrollment 2(d) Fully Immunized 3(e), (f)	4(a, c)	CY2000	75%	2003	2004	2005	80%
Wisconsin	2 yr. Old 1(a) Medicaid Enrollment 2(f) Fully Immunized 3(f)	4(a, b, c, d)	CY2001	41%	2003	2004	2005	pending
Wyoming	2 yr. Old 1(b) Medicaid Enrollment 2(c) Fully Immunized 3(a)	4(b)	6/15/00	55%	38%	2004	2005	pending

APPENDIX B

Definition of two-year old:

- 1(a) States choosing to measure number of two-year olds over a period of time (i.e. using State or Federal fiscal year, calendar year, or a point in time such as January 1).
- 1(b) States measuring by age (i.e. 24 - 35 months of age, between 19 and 35 months of age or 0 to 24 months of age).

Medicaid enrollment:

- 2(a) Twelve months enrollment and have no more than 30 - 45 days gap in enrollment.
- 2(b) Enrolled for at sample date selected.
- 2(c) Enrolled at least 6 months
- 2(d) Ever enrolled.
- 2(e) Enrolled in Medicaid managed care
- 2(f) Enrolled at least 10 months with no more than 45 day gap in enrollment

Fully immunized:

- 3(a) 4 DTP, 3 OPV, 1 MMR
- 3(b) 4 DTP, 3 OPV, 1 MMR, 1 Hib
- 3(c) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 3 HBV; HEDIS (2001 & 2000, Comb 1; 1999, Comb 2)
- 3(d) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 2 HBV; HEDIS (1999, Comb 1; 1998, Comb 2)
- 3(e) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 3 HBV, 1 VZV; HEDIS (2001 & 2000, Comb 2; 1999, Comb 3)
- 3(f) 4 DTP, 3 OPV, 1 MMR, 3 Hib, 3 HBV; HEDIS (2002, Comb 1)
- 3(g) 4 DTP, 3 OPV, 1 MMR, 3 Hib, 3 HBV, 1 VZV; HEDIS (2002 & 1, Comb 2)
- 3(h) 4 DTP, 3 OPV, 1 MMR, 4 Hib, 3 HBV, 1 VZV (ACIP schedule 1998)
- 3(i) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 2 HBV; HEDIS (1998, Comb 1)
- 3(j) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 3 HBV
- 3(k) 4 DTP, 3 OPV, 1 MMR, 4 Hib, 3 HBV (ACIP/AAP recommendations)
- 3(l) 4 DTP, 3 OPV, 1 MMR, 3 Hib (NIS)
- 3(m) 4 DTP, 3 OPV, 1 MMR, 1 Hib, 3 HBV, 1 VZV
- 3(n) 4 DTP, 3 OPV, 1 MMR, 2 Hib, 2 HBV, 1 VZV; HEDIS (1998, Comb 3)

Data Sources:

- 4(a) Immunization registry
- 4(b) Chart review
- 4(c) Administrative data
- 4(d) Survey
- 4(e) Alaska Permanent Fund

GLOSSARY OF TERMS

AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
CASA	Clinic Assessment and Software Application
CY	Calendar year
DTP/DTaP	Diphtheria, Tetanus, Pertussis/ Diphtheria, Tetanus, acellular Pertussis
EQR	External Quality Review
FFS	Fee-For-Service
GPRA	Government Performance and Results Act
HBV	Hepatitis B Vaccine
HEDIS	Health Plan Employer Data Information Set
HEDIS Hybrid	Hybrid - Using the above set along with other available data systems
Hib	Haemophilus Influenza type b
MCO	Managed Care Organization
MCP	Managed Care Program

MIS/DSS	Management Information System
MMR	Measles, Mumps, Rubella
OPV/IPV	Oral Polio Vaccine/Intramuscular Polio Vaccine
PCCMP	Primary Care Case Management Program

TUESDAY, MARCH 25, 2003.

ADMINISTRATION FOR CHILDREN AND FAMILIES

WITNESSES

WADE F. HORN, Ph.D., ASSISTANT SECRETARY, ADMINISTRATION FOR CHILDREN AND FAMILIES

KERRY WEEMS, ACTING ASSISTANT SECRETARY FOR BUDGET, TECHNOLOGY AND FINANCE, OFFICE OF THE ASSISTANT SECRETARY FOR BUDGET, TECHNOLOGY AND FINANCE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. REGULA. Well, I think we will get started this morning. We have two very important hearings, and we are pleased to welcome you, Mr. Horn. We go back to Ohio days. I told the Secretary this morning I was going to give him a pin that says, "Go Bucks" in place of his Badger pin. He does a great job, though, I must say. I like how where he is trying to take responsibilities back into focus at the Department. It has got to be exciting to be there.

Well, we are happy to welcome all of you to be testifying. And, Mr. Secretary, you can summarize your statement. We will put the whole thing in the record.

I will say that Head Start is being recognized, I think, more and more that early programs are vital for children, especially if they don't get any or at least not enough at home. And we have had some discussion as to where Head Start should go prospectively. To me, the important thing is that these kids get something more than how to play; that they get some skills along with the socialization, which seems historically the role of Head Start has been probably in the inception was socialization; but as the evidence becomes more compelling about the value of learning skills early, that there has been a movement in Head Start in another direction.

And I see, Ms. Hill, you run the program, am I correct, day in and day out? And maybe we would have some opportunity to just visit about the program. I think it is a very important program. And when I speak to teachers' groups, I have said, if I were in charge of the whole show, the lower the grade, the more they get paid, because those early influences—and it goes back to Head Start. Those early influences have to have a profound impact.

One of my missions as Chairman is to do what we can to reduce the dropout rate. I think it is tragic when a city like Cleveland has over 50 percent of these kids not finishing high school. But the dropout rate starts at Head Start and kindergarten and first grade, because if you go through the system and you can't work within it, you are going to be inclined to say the heck with it and drop out. And I think the real remediation of dropout has to start in the early, early years.

And when I was an elementary principal, I used to, not always, but I had a 20-room school, I would substitute when I had a teach-

er out. So I have been in every grade, and you really get an understanding of the importance; and we didn't have kindergarten, we just had first grade, but the importance of those early years in shaping a child's outlook toward education, towards school, toward teachers, toward the whole process. And Head Start can play a very important role in getting that child to have a positive attitude about the education process.

But you are here to tell us how to do it. You are the expert; I am just the Chairman. Mr. Horn, we will welcome your testimony.

Mr. HORN. Well, thank you, Mr. Chairman. It is a pleasure to appear before you today to discuss the President's budget request for the Administration for Children and Families for fiscal year 2004. Kerry Weems, the Acting Assistant Secretary for Budget, Technology and Finance, joins me at the table this morning.

The fiscal year 2004 budget for ACF is \$47,000,000,000, including \$33,500,000,000 in entitlement funds and \$13,500,000,000 in discretionary spending. I would like to take this opportunity to highlight some of the key programmatic initiatives in our request to strengthen families, support Presidential initiatives, and better serve vulnerable populations.

Welfare reform, as you know, continues to be a cornerstone of ACF's budget. Our request for TANF, child care, and child support reflects our commitment to strengthen and empower families.

First, our 2004 budget request reflects the President's 2003 plan to maintain funding for the tremendously successful Temporary Assistance for Needy Families Program. The number of dependent families has been cut by more than half since the advent of welfare reform in 1996, and child poverty rates are at historic lows. Child care funding provides a crucial service for helping families achieve self-sufficiency. Consistent with the administration's 2003 welfare reform proposal, the 2004 budget maintains the historically high level of funding dedicated to this purpose in both the Child Care and Development Block Grant at \$2,100,000,000 and the Child Care Entitlement at \$2,700,000,000.

We also know that families are empowered when children receive the financial support they are due. Consequently, our 2004 budget proposes additional child support legislation to enhance efforts to increase child support collected on behalf of children and families. When combined with opportunities to increase child support outlined in the President's 2003 budget, these proposals offer an impressive \$7,500,000,000 in additional child support for families over the next 10 years, at a net cost of only \$218,000,000 over the same period.

In addition to these priorities—

Mr. REGULA. Say that again? Provides a \$7,000,000,000 increase did you say?

Mr. HORN. If you take our 2004 child support proposals and combine them with our 2003 child support proposals, over the next 10 years, if enacted, they will yield \$7,500,000,000 in additional child support collected and put in the hands of families, at a net cost to the government of only \$218,000,000.

Mr. REGULA. How do you get the net cost if we are spending \$7,000,000,000?

Mr. HORN. No. That is the child support that is collected from the noncustodial parent.

Mr. REGULA. Okay. From other sources, in other words.

Mr. HORN. From the noncustodial parent. That is right.

In addition to these priorities, our budget includes new initiatives to strengthen Head Start and child welfare services. Head Start, as you are well aware, has been serving preschoolers and their families for nearly 40 years. The Head Start budget request for 2004 is \$6.8 billion, a \$148 million increase over the enacted 2003 appropriation. This funding, coupled with greater discretionary authority to allocate resources contained in our Head Start reauthorization proposal, will be used to maintain current service levels, provide a 2.2 percent cost of living adjustment to Head Start staff, and increase Head Start enrollment by over 10,000 children.

Furthermore, under the President's proposal, States would be offered the opportunity to coordinate State-administered preschool programs with Head Start programs in exchange for meeting certain accountability requirements. In addition, States choosing this option must describe how they will maintain at least the same number of eligible Head Start children being served under the State plan as are currently being served, and continue to provide the comprehensive range of services for children supported by Head Start funds.

For child welfare, we propose to strengthen services to vulnerable children and help States develop a seamless system of services through an innovative child welfare financing option. Under this alternative, for the current Title IV Foster Care Entitlement Program, States could choose to administer their foster care program within a fixed allocation of funds over a 5-year period. This option would give States far greater flexibility in determining how to use these funds with regard to services provided and populations served, thereby allowing States to develop innovative ways to ensure the safety, permanence and well-being of children in their child welfare programs. If States that elect to use this option experience emergencies affecting their foster care system, they may apply under certain conditions for access to additional funding from the TANF contingency fund.

ACF's total 2004 request for foster care, adoption assistance and independent living programs is \$6,800,000,000. Additionally, we request \$505,000,000 in funding for the Safe and Stable Families Program, a \$100,600,000 increase over the 2003 enacted level.

In addition to these major legislative initiatives, the President is committed to providing sufficient discretionary funds to adequately support his key priorities, including \$100,000,000 for the Compassion Capital Fund, a \$65,000,000 increase over the enacted 2003 level; \$50,000,000 for the Mentoring Children of Prisoners Program, a \$40,000,000 increase over the 2003 appropriation; \$60,000,000 for independent living training vouchers, \$18,000,000 over the 2003 enacted level; \$20,000,000 for a new program dedicated to the promotion of responsible fatherhood and healthy marriages; and \$10,000,000 for maternity group homes, to provide young pregnant and parenting women with coordinated social services and transitional living arrangements through faith-based and community-based organizations.

The 2004 request for Federal administration is \$181,000,000, an increase of \$7,700,000 over the 2003 enacted level. This funding level will support a workforce of 1,476 FTEs, 40 FTEs below the 2003 enacted level, while directing funds to support child welfare monitoring efforts through the use of contract support. It also will focus on identifying and reducing erroneous payments, and assisting in the development of the Department's Unified Financial Management System and HHS Information Technology Enterprise Infrastructure.

In conclusion, the proposed ACF budget for 2004 provides a balanced response to our efforts to empower families, support key Presidential priorities, and protect our Nation's most vulnerable populations. We look forward to working with this Committee and Congress in achieving these goals. Thank you, Mr. Chairman. I would be happy to answer any questions you might have.

[The information follows:]

Witness

**Wade F. Horn, Ph.D.
Assistant Secretary
Administration for Children and Families**

Accompanied by

**William Beldon
Acting Deputy Assistant Secretary for Budget
U.S. Department of Health and Human Services**

and

**Kerry N. Weems
Acting Assistant Secretary for Budget**

Statement

Of

Wade F. Horn, Ph.D.

Administration for Children and Families

Department of Health and Human Services

Before the

**Subcommittee on the Department of Labor, Health and Human Services,
Education and Related Agencies**

Committee on Appropriations

U.S. House of Representatives

March 25, 2003

Mr. Chairman and members of the subcommittee, I am honored to appear before you today to discuss the President's budget request for the Administration for Children and Families (ACF) for FY 2004. William Beldon, the Acting Deputy Assistant Secretary Budget, joins me at the table.

The FY 2004 budget for ACF is \$47.0 billion, a net decrease of \$539 million, or 1.1 percent, from the FY 2003 enacted level. Our request includes \$33.5 billion in entitlement funds (\$887 million below the FY 2003 budget) and \$13.5 billion in discretionary spending, a net increase of \$345 million, or 2.6 percent, over the FY 2003 budget. In addition to seeking continued funding for a wide range of programs serving some of the nation's most vulnerable populations, the ACF budget targets more resources to empower America's families, provides States with increased flexibility in a number of programs so that they can better serve vulnerable children and families, and supports key Presidential priority initiatives. Our budget for FY 2004 also reinforces our commitment to the participation of faith and community-based organizations in ACF's programs, and it continues to focus on the President's management agenda. I would like to turn to some of the key programmatic initiatives in our request to demonstrate how these goals will be met.

Empowering Families

The Temporary Assistance for Needy Families (TANF) program continues to be a cornerstone of ACF's budget. Our FY 2004 budget request reflects the President's FY 2003 plan to maintain funding for this critical program through reauthorization. Welfare reform has been a tremendous success. Since TANF was created in 1996 the number of dependent families has been cut by more than half. Child poverty rates are at or near historic lows. The success of the first phase of welfare reform efforts provides an impetus to move to the next phase. We appreciate the quick action by members of the House to pass H.R. 4 in so early in this session of Congress.

Families are empowered when children receive the financial support they are due. Our FY 2004 budget, therefore, proposes additional child support legislation to enhance and expand the existing automated enforcement infrastructure at the Federal and State level and increase support collected on behalf of children and families. When combined with the opportunities to increase child support outlined in the President's FY 2003 budget (expanded passport denial, offset of certain Social Security benefits, optional pass through of child support to families on TANF, among others), these proposals offer an impressive \$7.5 billion in increased child support payments to families over 10 years. Once again, we appreciate the House action to include these key FY 2003 child support proposals in H.R. 4.

Child care funding provides a crucial service for helping families achieve self-sufficiency through work. Consistent with the Administration's FY 2003 welfare reform proposal, the budget maintains the historically high level of funding dedicated to this

purpose in both the Child Care and Development Block Grant, at \$2.1 billion, and the Child Care Entitlement, at \$2.7 billion. States also would continue to have flexibility to provide child care services using TANF funds and Social Services Block Grant funds. In addition, under our welfare reform proposal States would have the ability to use unobligated TANF balances (approximately \$2.7 billion at the end of FY 2002) on services such as child care.

Head Start has been serving preschoolers and their families for nearly 40 years. The Head Start budget request for FY 2004 is \$6.8 billion, a \$148 million increase over the enacted FY 2003 appropriation. This funding, coupled with greater discretionary authority to allocate resources contained in our Head Start reauthorization proposal, will be used to maintain current service levels, provide a 2.2% cost of living adjustment to Head Start staff, and increase Head Start enrollment by approximately 10,500 children. Furthermore, under the President's proposal, States will be offered the opportunity to coordinate state-administered preschool programs with Head Start programs in exchange for meeting certain accountability requirements.

States wishing to participate must submit a State plan for approval to the Secretary of Health and Human Services and the Secretary of Education. In these plans, States choosing this option must address how they will work with the public school systems to develop goals for all preschool programs in the State; identify guidelines that programs can use to achieve these goals; devise an accountability system to determine whether children are achieving the goals; provide professional development for preschool teachers and administrators; and help parents provide support for children to succeed in kindergarten. In addition, States must describe how they will maintain at least the same number of Head Start eligible children being served under the State plan as are currently being served, and continue to provide the comprehensive range of services for children supported by Head Start funds.

For child welfare, ACF proposes to strengthen services to vulnerable children and help States develop a seamless system of services through an innovative child welfare financing option. Under this alternative to the current title IV-E foster care entitlement program, States could choose to administer their foster care program (foster care maintenance payments program and the associated administrative costs) within a fixed allocation of funds over a five-year period. This option would give States far greater flexibility in determining how best to use these funds with regard to services provided and populations served. The flexible funding will allow States to develop innovative ways to ensure the safety, permanency and well-being of children, tailored to meet the needs of their child welfare programs. If States that elect to use the option experience emergencies affecting their foster care system they may apply, under certain conditions, for access to additional funding from the TANF Contingency Fund.

ACF's total FY 2004 request for the Foster Care, Adoption Assistance and Independent Living programs is \$6.8 billion. This request includes nearly \$5 billion to support the Foster Care Program and includes the child welfare financing option I have described. The budget also includes \$1.7 billion for the Adoption Assistance program, as

well as \$140 million for the Independent Living Program. Additionally, we request \$505 million in funding for the Safe and Stable Families Program, a \$100.6 million increase over the FY 2003 enacted level.

Finally, community services can provide an important empowerment tool for families; however, we must work to ensure that Federal funds are being spent as effectively as possible. Our request for FY 2004 includes \$495 million for the Community Services Block Grant (CSBG), a \$151 million reduction from FY 2003, \$32.4 million for Community Services Discretionary Activities, or \$31 million less than in FY 2003, and \$25 million for Individual Development Accounts, the same as in FY 2003. The reduction in CSBG funds indicates a lack of strong performance data for the program. Our reauthorization proposal includes provisions that would strengthen program accountability in CSBG. We also propose to streamline services by eliminating the Community Food and Nutrition Program, the Rural Community Facilities Program, and National Youth Sports - all of which duplicate programs funded by other departments or CSBG.

Presidential Priority Initiatives

The President is committed to providing sufficient discretionary funds to adequately support his key priority initiatives. This budget request reflects this commitment in the following areas.

The President has been a leader in recognizing the important role that faith-based and community-based organizations play in delivering services to the public. Our FY 2004 budget seeks \$100 million for the Compassion Capital Fund, \$65 million more than enacted for FY 2003. The fund will continue to be used for grants to intermediary organizations to build the capacity of faith-based and community-based organizations to expand their services to the poor and vulnerable.

The arrest and incarceration of a parent often has negative consequences for children. For FY 2004, we are proposing to increase the funding of the recently authorized Mentoring Children of Prisoners program from the \$9.9 million enacted in FY 2003 to \$50 million in FY 2004. These funds would be used to establish or expand competitive grants to governmental and non-governmental entities for projects to mentor children of incarcerated parents and parents recently released from prison.

The importance of an involved, committed and responsible father in a child's life cannot be overestimated, so as proposed in FY 2003, our request for FY 2004 includes \$20 million for the promotion of responsible fatherhood and healthy marriages. This initiative complements the family formation activities proposed for TANF by providing for the promotion and support of involved, committed, and responsible fatherhood and encouraging the formation and stability of healthy marriages.

To provide youth with an additional resource to prepare for independent living, increasing the prospect that they will be able to secure work and become contributing

members of society, our budget includes \$60 million for Independent Living Training Vouchers - \$18 million over the FY 2003 enacted level.

For FY 2004, we again are requesting \$10 million for Maternity Group Homes. These new funds would provide young pregnant and parenting women with access to faith-based and community-based maternity group homes through the use of targeted grants to organizations, where a range of services such as child care, education, job training, counseling, access to transitional living opportunities, and parenting education can be provided.

Serving Special Populations

Our FY 2004 budget supports helping those who are in especially vulnerable circumstances. First, we are seeking \$2 billion for the Low Income Home Energy Assistance Program (LIHEAP), a \$200 million increase over the FY 2003 enacted level. This request includes \$1.7 billion for formula block grants to States and \$300 million for contingency funding, in recognition of the increasing demands for LIHEAP assistance in order to help low-income households with their heating or cooling needs.

In addition to requesting \$428 million in FY 2004 for programs serving refugees, asylees, Cubans/Haitians, and victims of torture and trafficking, our budget provides additional funding for the care and safety of unaccompanied alien children. The Homeland Security Act transferred responsibility for these children from the Immigration and Naturalization Service to ACF's Office of Refugee Resettlement (ORR) in 2003. With a budget request of \$34 million, ORR is expected to serve more than 5,000 unaccompanied alien children.

The President's Management Reform Agenda

The FY 2004 request for Federal Administration is \$181 million—an increase of \$7.7 million over the FY 2003 enacted level; this funding level will support a workforce of 1,476 FTEs—40 FTEs below the FY 2003 enacted level. Additional funds are included in this request to support child welfare monitoring efforts through the use of contract support, a stronger focus on identifying and reducing erroneous payments, and development of the Department's Unified Financial Management System and HHS Information Technology Enterprise Infrastructure.

Conclusion

In conclusion, I would like to emphasize that the proposed ACF budget for FY 2004 provides a balanced response to our efforts to empower families, support key Presidential priorities, and protect our nation's most vulnerable populations. We look forward to working with the Congress on achieving these goals. Thank you, Mr. Chairman. I will be happy to answer any questions.

Dr. Wade F. Horn

Assistant Secretary for Children and Families

Wade F. Horn, Ph.D. was named the Assistant Secretary for Children and Families in the Administration for Children and Families, U.S. Department of Health and Human Services, on July 30, 2001. The Administration for Children and Families is responsible for programs that promote the social and economic well-being of families. ACF's programs include Temporary Assistance to Needy Families, foster care, adoption assistance, family preservation and support, Head Start, child care, child support enforcement, runaway and homeless youth, low income home energy assistance, community services, refugee resettlement, mental retardation and developmental disabilities.

Prior to this appointment, Dr. Horn was President of the National Fatherhood Initiative, whose mission is to improve the well-being of children by increasing the number of children growing up with involved, committed and responsible fathers in their lives.

From 1989-1993, Dr. Horn was the Commissioner for Children, Youth and Families and Chief of the Children's Bureau in the Administration on Children, Youth and Families. He also served as a Presidential appointee to the National Commission on Children from 1990-1993, was a member of the National Commission on Childhood Disability from 1994-1995, and the U.S. Advisory Board on Welfare Indicators from 1996-1997. Prior to these appointments, Dr. Horn was the Director of Outpatient Psychological Services at the Children's Hospital National Medical Center in Washington, D.C., and an Associate Professor of Psychiatry and Behavioral Sciences at George Washington University. From 1993 to 2001, Dr. Horn was also an adjunct faculty member at Georgetown University's Public Policy Institute, and an affiliate scholar with the Hudson Institute.

Dr. Horn is the author of numerous articles on children and family issues, including a weekly newspaper column entitled *Fatherly Advice*, and is the co-author of several books including *The Better Homes and Gardens New Father Book* (Meredith Books, 1998) and *The Better Homes and Gardens New Teen Book* (Meredith Books, 1999.) He is also the lead editor of *The Fatherhood Movement: A Call to Action* (Lexington Books, 1998.) Dr. Horn is frequently featured on television and radio as a child development expert and commentator. He has appeared on NBC's *Today Show*, *Good Morning America*, CBS *This Morning*, *McNeil-Lehrer News Hour*, *20/20*, *48 Hours*, *ABC World News Tonight*, *CNN*, *NBC Nightly News*, *CNBC*, *Fox News Channel*, *CNN* and *MS-NBC*.

Dr. Horn received his Ph.D. in clinical child psychology from Southern Illinois University in 1981. He lives in Gaithersburg, Maryland, with his wife and two daughters.

Department of Health and Human Services
Office of Budget

William R. Beldon

Mr. Beldon is currently serving as Acting Deputy Assistant Secretary for Budget, HHS. He has been a Division Director in the Budget Office for 16 years, most recently as Director of the Division of Discretionary Programs. Mr. Beldon started in Federal service as an auditor in the Health, Education and Welfare Financial Management Intern program. Over the course of 30 years in the Budget Office, Mr. Beldon has held Program Analyst, Branch Chief and Division Director positions. Mr. Beldon received a Bachelor's Degree in History and Political Science from Marshall University and attended the University of Pittsburgh where he studied Public Administration. He resides in Fort Washington, Maryland.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
BIOGRAPHICAL SKETCH

NAME: Kerry N. Weems

POSITION: Deputy Assistant Secretary for Budget

BIRTHPLACE: Portales, New Mexico

EDUCATION: B.A., Philosophy, New Mexico State University, 1978
BBA, Management, New Mexico State University, 1978
MBA, University of New Mexico, 1981

EXPERIENCE:

January 24-Present	Acting Assistant Secretary for Budget, Technology and Finance
June 2002- Present	Deputy Assistant Secretary for Budget, HHS
2001 - 2002	Acting Deputy Assistant Secretary for Budget, HHS
1996 - 2002	Director, Division of Budget Policy, Execution and Management, HHS
1991 - 1996	Chief, Budget Planning Branch, HHS
1988 - 1991	Program Analyst, Office of Budget, HHS
1983 - 1988	Program and Budget Analyst, HHS (Social Security Administration)
1981 - 1983	Staff Member, United States Senate

HONORS AND AWARDS:

2001	Presidential Rank Award
1995	Secretary's Distinguished Service Award
1993	HHS Senior Management Citation

UNAUTHORIZED PROGRAMS

Mr. REGULA. Thank you. I note a number of the programs you described are not yet authorized. Am I correct that you have money in the budget, but it is not an authorized program?

Mr. HORN. The one that needs authorization is the program for responsible fatherhood and healthy marriages; however, it was contained within H.R. 4 which passed the House, but still it awaits action in the Senate.

HEAD START PROGRAM DESIGN

Mr. REGULA. I noted that an article in the Post recently, that Montgomery County has proposed to abandon the traditional Head Start program. I found that an interesting development. Why? And what is the substitute?

Mr. HORN. Well, I am not familiar with all of the details with what happened in Montgomery County. My understanding is that Montgomery County and the State have traditionally put a lot of money into the Head Start program directly in order to expand the enrollment in Head Start. What they are interested in doing is entertaining an alternative in which they would, rather than provide the money directly to the Head Start program, set up a preschool program for low-income children in Montgomery County that would operate under a little bit different rules than Head Start does with, in their mind, a stronger focus on education in the preschool years.

It is precisely because of situations like that that the President has proposed a new option to allow States the ability to submit a plan to the Secretaries of HHS and Education in which they would indicate how they would better coordinate Head Start with State-administered preschool programs and, at their option, child care.

Mr. REGULA. So his plan would be to give the States the option of staying in the present range or going into the education program.

Mr. HORN. That is right. And there is a lot of confusion about that, at least if you take from the media accounts what the President's proposal contains. The President is not proposing to block grant the Head Start program. Rather, what the President is interested in doing is providing States with the option of submitting a plan to the Secretaries of Education and HHS. In that plan they would have to indicate how they would better coordinate State-administered preschool programs in Head Start and, at their option, child care. There are certain conditions that they would have to meet in that plan. They would have to assure that they would continue to spend as much State dollars as they are currently spending on State preschool programs or contributing to Head Start. They would have to demonstrate they would continue to serve at least as many kids that are currently being served. They would have to submit a plan for professional development across both the State preschool programs and Head Start, and they would have to give assurances they would continue to provide comprehensive services to children who continue to be funded with Head Start funds.

So it is not a block grant proposal, but it is an innovative way for a Governor to start to coordinate State-administered preschool programs with Head Start.

Mr. REGULA. Do you think that reflects a desire to make the program have a little more significant education component as opposed to a custodial?

Mr. HORN. The President, simultaneous with this option, is also aggressively pursuing an initiative to strengthen the education component in Head Start. So, for example, we held a summer teacher training session last year in which we trained over 3,000 Head Start teachers in the latest knowledge about how children develop early literacy skills. We also did some follow-up training with a group of those teachers so that we can also train them to become trainers themselves so they can go back to their local Head Start programs and teach the rest of the teachers in those programs this new knowledge base that we have. Further, we are in the development phase of a new national reporting system that would assess the degree to which children are actually progressing in the development of early literacy skills.

So that initiative is ongoing at the same time that the President is proposing the State option. So, the State option is not all of what the President is proposing to do to strengthen the education component within Head Start.

HEAD START TEACHERS

Mr. REGULA. How about the people that are conducting the programs, the so-called teachers? Are you seeking a different set of skills on the part of the individuals you are putting into these classrooms?

Mr. HORN. Well, as I know you are aware, Congress required that Head Start by, I believe, 2004 have at least 50 percent of their teachers with an associate's degree or higher in an area relevant to early childhood education. I am very pleased to report that we have actually met that prior to the 2004 deadline, and we are now above that 50 percent mark. So, the President feels strongly that it is important to have qualified teachers in Head Start, and we are working diligently to expand the number of teachers in Head Start that have a relevant degree.

Mr. REGULA. Does the evidence show that these programs—and I presume it varies from place to place—that these programs do allow these students, children to start on a fairly equal basis with those that are not a part of the Head Start program? That is the goal at least.

Mr. HORN. It certainly is the goal, to bring economically disadvantaged children up to the same level as their more economically advantaged peers when they enter the public school system.

I think the most objective read of the literature relating to the effectiveness of Head Start would suggest that in a number of areas, not all, but in a number of areas, children who experience Head Start do make gains relevant to their economically disadvantaged peers who do not get Head Start or a State preschool experience, but they still lag behind in many areas quite significantly compared to their more economically advantaged peers. So it appears that we have helped children through Head Start, but we

have not yet been successful in getting to the point where we can say economically disadvantaged children who get Head Start are starting kindergarten at the same level as their more economically advantaged peers.

RIPPLE EFFECT OF HEAD START

Mr. REGULA. Does the evidence indicate that having a child in Head Start has a ripple effect with the parents and with the siblings of that child? Is there some spillover?

Mr. HORN. There does seem to be some evidence that there are improvements made in terms of the parents. We know, for example, that there is some improvement in terms of the frequency with which parents read to their children at their home as a consequence of enrollment in Head Start. We know that there is some decrease in the frequency with which parents use spanking as a disciplinary measure as a consequence of enrollment in Head Start. And there is some evidence to suggest that parents who are actively involved in Head Start, particularly with the social services component, particularly those who enroll in other kinds of services such as welfare-to-work programs and so forth, do make some economic gains. I am not aware of evidence about the effect it has of a spillover to siblings, however.

Mr. REGULA. Mr. Simpson.

CHILD SUPPORT ENFORCEMENT PROPOSALS, 2003

Mr. SIMPSON. Thank you, Mr. Chairman.

And, Dr. Horn, I appreciate your being here this morning. I am sorry I was late and didn't get your full testimony, but I will read it all.

One of the issues that I probably have come to my office more than any other is that of child support and the enforcement of that, particularly when parents live in different States. And it seems like we have a very difficult time getting one State to enforce the child enforcement or child support agreements of another State. I noticed in here that you said the legislation will be proposed under the Child Support Enforcement Program to enhance and expand the existing automated and enforcement infrastructure at the Federal and State level.

What is the Federal Government's role, and what legislation are you going to propose, and how is that going to allow for enhanced enforcement of child support?

Mr. HORN. We have a number of proposals contained within our 2003 budget request and now also additional ones in our 2004 budget request. Let me give you some examples.

First of all, the 2003 budget requests have not yet been enacted, so they are still proposals at this point. We are suggesting, for example, that we provide some financial incentive to States so that they are more willing to pass through, while the family is still on cash welfare, child support that is collected on behalf of the child, directly to the family, as opposed to using it as a cost recoupment strategy for the costs of welfare. Our proposal specifically says we will provide States with financial incentives for passing through up to \$100 a month of child support that is collected on behalf of a

child where the family is on cash TANF and/or \$50 above their current pass-through amount, whichever is the greater.

We also proposed in our 2003 budget a simplified distribution procedure in which once a family has left cash welfare, all of the child support that is collected on behalf of that child, including arrearages, is passed directly on through to the child. And those two alone will enhance the amount of money that families are receiving in terms of child support, because those amounts would no longer be used as a cost recoupment strategy.

We also in the 2003 budget request would reduce the threshold for passport denials from \$5,000 to \$2,500. Passport denials have been a very effective strategy for recouping additional child support payments. We also suggest that, every 3 years the family is on cash TANF, there ought to be a review of the child support award. We think that will help to enhance child support collections, since people's incomes tend to grow over time, and adjustments can be made if we have a systemic procedure for reviewing them.

CHILD SUPPORT ENFORCEMENT PROPOSALS, 2004

I will give you some examples of our proposals in the current 2004 budget. One is precisely to your point about situations where the custodial parent may have assets in one State, but the child resides in a different State. These come into play when we have multistate financial institutions, you know, banks that have branches in various States. Some States will not go after the assets of a noncustodial parent if those assets are in a multistate financial institution and are in a different State than the child resides. So, if the child resides in Virginia, and the noncustodial parent's assets are in Washington, D.C., Virginia does not go after those assets in Washington, D.C.

We would suggest that the Secretary ought to have the authority to be able to go after those assets to assist the State in collecting them, and then saying to the States, these are for distribution to the family.

We also have a proposal that would intercept gaming winnings after a certain threshold is crossed, that threshold basically being the threshold where someone with gambling winnings would have to fill out an IRS form indicating how much that they won. We would set up a secure Website where, if someone had hit that threshold, the gaming institution would then have to check that Website to see whether they owed back child support, and, if so, that money would be sent to the Federal Government. We would put it in a child support lockbox and then distribute it to the State for distribution back to the family.

We think that would do two things. One, it would collect additional child support from those people who have gaming winnings, but we also think it may provide a disincentive for someone who owes child support from going and gambling away their resources in the first place, instead of fulfilling their child support obligations to their children.

So there is a big package that we have. All told it would bring in over 10 years \$7,500,000,000 in additional child support money directly to families, to children who are owed that support, at a net cost to the Federal Government of only \$218,000,000. So we are

very excited about this package of proposals, and we look forward to working with you in enacting them.

Mr. SIMPSON. Has that package been proposed yet? Have you bought that up yet?

Mr. HORN. It has been proposed as part of our budget request, but we have not submitted legislative language. We would be very pleased to work with the committee in doing so.

Mr. SIMPSON. Thank you. I appreciate that. I look forward to working with you on that. As I said, it is one of the biggest issues that I have to deal with from constituent concerns in the district. And it gets difficult when you have multistate jurisdiction and what exactly the Federal role is in that, trying to get courts to enforce different settlements in different States. So I appreciate your work on that and look forward to working with you on it. Thank you.

HEAD START PROPOSALS

Mr. REGULA. Mrs. Lowey.

Mrs. LOWEY. Thank you, Mr. Chairman.

And thank you for your testimony. As you know, Head Start merges literacy activities with programs in good nutrition, vision screenings, proper hygiene. It also recognizes, and I think that is particularly important, the need to bring parents into the developmental process by providing them with support services in and out of the home, such as access to comprehensive health care and social workers, peer counseling, parenting programs. And as a mother and grandmother, I know that it takes a lot more than basic reading skills to get our children prepared for learning. Kids' emotions, personality, social surroundings are just as important as their IQ when first entering school, and Head Start is working helping to narrow the gap between disadvantaged children and all children in vocabulary and writing skills.

In addition, we have seen evidence that Head Starters are less likely to need special education classes, repeat grades, commit crimes, and they are also more likely to finish high school and college.

Despite these results, the administration is quickly moving forward with plans to implement the national reporting system for all 4- and 5-year-olds. The plan would require for each of the 525,000 4-year-olds in Head Start to sit for a standardized 20- to 30-minute test in literacy and other skills.

With all due respect, Mr. Horn, even No Child Left Behind does not mandate testing until third grade, and while I agree with the need to conduct ongoing child assessments, I think we have to be careful about what factors we focus on to determine if a program is successful in meeting its goals. Earlier this year I received a letter from numerous distinguished child education and development experts who have strong reservations about the administration's national reporting system. And although I hesitate to think we would move forward with this plan at all, at minimum I would hope the administration would take their concerns into account while developing the testing program. And the field tests, I understand, are scheduled to begin just 2 days after the OMB comments are due, 2 days after the comments are due. Why are we asking

for the comments if we are not going to pay any attention to the comments? How can you truly respond or address concerns raised during the comment period in just 2 days?

Also, how does the proposed national reporting system fit with the administration's proposal to send the programs back to the States? Will States' funding be determined by the results of the test for Head Start's 4-year-olds?

And in terms of funding, I want to make another point or ask another question, because you mentioned the funding before. In your Head Start proposal, you would require the States to develop a professional development plan, but offer no official funds to implement. I was delighted to hear that more than 50 percent of the Head Start staff already has an advanced degree. And what I have heard is more than 40 States already have a professional development and career ladder plan, but they all tell me that funding is the problem. Many States are cutting back or eliminating programs to help early childhood teachers further their education, but I don't see any new money for this purpose in your budget, either in Head Start or the Child Care and Development Block Grant.

I spoke to a group, a huge group, about 200 of Head Start teachers, and they all want to be advancing themselves and advancing their career. But what you actually do is suggest cutting back on the Head Start quality set-aside that helps programs fund education and salary increases. The small cost of living increase in Head Start does not allow more teachers to get an AA or a BA degree, pay the cost of research-based training, or raise teachers salaries once they earn the degrees so they will stay in their job.

So, forgive me for the long question, but around here you just have to get it out. How do you see professional development happening in States' Head Start prekindergarten child care program without any additional funds? How do you do that?

Mr. HORN. Well, first of all, let me say that as a child psychologist, I agree with you that it is very important when you are dealing with young children to involve the parents to the maximum extent possible. And Head Start, I agree with you, has always been about not just providing services to the child, but also services to the parent and getting the parent involved in the early education of their children. And there is nothing in the administration's proposals that would take away 1 minute of activity in that area even with the State option. There is a requirement that the States give assurances that the comprehensive services that are currently provided to Head Start children would remain for those who are supported with Head Start funds, including parent services.

So I agree with you. I think it is very critical, and the administration is not trying to compromise the parent services that are delivered through Head Start.

HEAD START ASSESSMENT

In terms of assessment, as I said, I am a clinical child psychologist, and there are ways of assessing preschool children that are appropriate, and there are ways of assessing preschool children that are inappropriate. We assess preschool children all the time. We assess children at 1 minute and 5 minutes after they are born. It is called an Apgar score. Pediatricians assess children all the

time against developmental norms. And, in fact, currently in every Head Start program in America, they are assessing children on a variety of different measures in a variety of different ways.

What the President is interested in doing is ensuring that there is some core set of measures upon which all children at Head Start are assessed, so that we can determine which Head Start programs are in need perhaps of additional training and technical assistance to achieve better outcomes for children. And the most recent battery that I have seen suggests not a 20- to 30-minute assessment, but more of a 12- to 15-minute assessment precisely because, you are right, having 4-year-olds, let alone 3-year-olds, sit down for a half hour in a row can be challenging. So we are committed to doing this in a way that is thoughtful, in a way that is appropriate, given the developmental skills of children at that age.

We have been soliciting comments not just in this official comment period, but all the way up to this point in a variety of different forums from a variety of different actors, including Head Start teachers, Head Start administrators, child development experts and so forth. And we think that we have constructed a system that, in fact, recognizes the developmental appropriateness of the context in which we would be implementing the system.

We started actually with looking at the congressionally mandated outcomes in the 1998 Head Start reauthorization. We said let us start there and let us determine which of these 13 outcomes that Congress mandated in 1998 have developmentally appropriate measures that are valid and reliable for use with 4-year-olds. And if we don't have a measure of those, any of those 13 outcomes, we won't assess children in those outcomes. We will send that over to the National Institutes for Child Health and Development and have them develop something. But for those where we have a developmentally appropriate and reliable and valid measure for use with 4-year-olds, then that is what we are considering using in this national reporting system.

So we think we have been thoughtful, but we still want to hear from the general public and as well as others in terms of the specifics of our battery.

HEAD START PROFESSIONAL DEVELOPMENT

In terms of professional development, you are exactly correct. We need to make sure that there is, in fact, a plan for ensuring that there will be adequate professional development for teachers who are working with preschoolers. That is why part of the President's proposal requires not only that this would be a nice thing to do, but how states are actually going to do it, and where the resources are going to come from. And the President's plan does include an amount of money from which States could draw down their proportional share, if they choose this option, that they could use to implement some of these things like professional development plans.

Mrs. LOWEY. I probably don't have any time to pursue it, but just maybe one quick, since there are so few of us. Is that from the total grant that they can draw down for professional development, or additional money for professional development?

Mr. HORN. There is currently a 2 percent set-aside in the statute for training and technical assistance. That 2 percent translates to

about \$170,000,000 right now for the overall Head Start program. What we are suggesting is States that choose this option could draw down their proportional share of that amount, so that they could implement the kinds of training and technical assistance activities that you are describing.

Mrs. LOWEY. And given the additional education of the teachers, does the appropriation which you are recommending provide additional money? If they are going to get this education, and they are more skilled, how are you going to keep the skilled people in the Head Start program?

Mr. HORN. Well, our proposal does include a 2.2 percent COLA for Head Start staff, including teachers, and then it also includes the ongoing amount of money that we provide to grantees in their training and technical assistance budgets, which they can use for further training and professional development.

Mrs. LOWEY. Thank you, Mr. Chairman.

HEAD START DELIVERY SYSTEMS

Mr. REGULA. We will maybe have another round.

If I understand you correctly, the way in which this is constructed in every community could vary as to the number of years, as to a pre-Head Start and the Head Start, as to the education requirements for the teachers. Is there a lot of autonomy on the part of the administrating agencies? And I guess even the administration could be under the—a school district could be an applicant for a Head Start program. Am I correct?

Mr. HORN. Under the current program, certainly. In fact, a good percentage of the Head Start programs right now are school systems.

Mr. REGULA. So there would be potentially a wide variety of ways in which this program is administered from communities to communities.

Mr. HORN. There is already a wide variety of ways that it is administered. That is right. And under the President's proposal, with the State option, we don't want to prejudice how a State might propose to better coordinate these programs, but there certainly are a myriad of ways that they could do that.

Mr. REGULA. So I guess you are saying, for every community, what works is what counts.

Mr. HORN. I work for a President who wants to manage by results. And he says, you know, good intentions are better than bad intentions, but we have to measure more than simply good intentions.

Mr. REGULA. Mrs. Roybal-Allard.

COMMUNITY SERVICES PROGRAMS

Ms. ROYBAL-ALLARD. Thank you, Mr. Chairman.

Mr. Horn, in your statement you mentioned that community services can provide an important empowerment tool for families. However, in your budget you propose cuts to the community services programs, including the Community Service Block Grant, by about \$182,000,000 below the fiscal year 2003 appropriated level. And one of the things that you use as your rationale is that there is a lack of strong performance data for the programs. Now, since

this is a pass-through program to community action agencies, I would imagine that there would be varying types of success within the program. And my question is, what are your reasons for the significant cuts that you are proposing for this program, particularly now, without any kind of study or rationale in terms of singling out the good performing versus those that are not performing as well? Do you have that kind of data, or is that something that still has to be gathered?

Mr. HORN. We have no data that would indicate the effectiveness of the services that are being provided through the Community Services Block Grant. And what we are proposing is that we are going to be submitting a proposal that would mandate such an outcomes-oriented system with the idea that, once this is implemented, the States would be empowered to recompute those grants if a particular community action agency was not achieving effective outcomes.

Ms. ROYBAL-ALLARD. And those are the provisions that you referred to for accountability?

Mr. HORN. Yes.

Ms. ROYBAL-ALLARD. I guess my concern is that you are taking away the money of even the good-performing agencies that would curtail their ability to provide important services before you even have the information. It seems like it is being done backwards, so even the good performers are being punished along with those that don't perform as well. And I am trying to understand your rationale for that, and I can't. Could you explain that?

Mr. HORN. Again, the rationale is that we just don't have any information on the effectiveness of this particular program.

Ms. ROYBAL-ALLARD. But wouldn't it make more sense to get that data, that performance data, to evaluate these agencies that you yourself have said provide a very important role in the community, evaluate them, see where some of the problems can be corrected, and then determine where the cuts should be, rather than just cutting everybody and negatively impacting the services of these agencies?

Mr. HORN. Well, this is a tight budgetary time. And given the absence of information as to the effectiveness of this program, our budget proposal reflects a redirecting of resources to higher-priority areas.

Ms. ROYBAL-ALLARD. Well, you said that you don't know the effectiveness of this program, but you also say that they provide an important empowerment tool for families in your statement. So there seems to be a little bit of a contradiction there. If these are important programs, then it seems to me that every effort should be made to first find out where the problems are before any cuts are made, because what we are talking about is not something in abstract. What happens to these programs is directly going to impact people and communities. And I hope that you will look at that and not cut off services before you even know whether or not there is value in them.

Mr. HORN. I understand your concern.

UNACCOMPANIED ALIEN CHILDREN

Ms. ROYBAL-ALLARD. The second question I have has to do with the Refugee and Entrant Assistance Program, and one of the reasons I am interested in that is because I also sit on the Homeland Security Subcommittee. Your testimony refers to the transfer of unaccompanied alien children from the Immigration and Naturalization Service to your Office of Refugee Resettlement. What is the status of this changeover, and is the process working? And what are some of the obstacles, if any, that you are encountering? I am particularly interested in your activities as they relate to the Department of Justice, Homeland Security, and the State Department.

Mr. HORN. As you may be aware, the transfer of that program was effective on March 1st of this year. So, we have only had a relatively short period of time of directly administering this program. Of course, we were working with INS and the Justice Department in preparing for this transfer, but we have only had the program since March 1st. And so we are working now to determine what kinds of resources we need for this program, and we look forward to sharing that information with you as it becomes clear to us what kinds of resources are necessary for this program.

Ms. ROYBAL-ALLARD. And understanding that it is just starting, the process is just starting, are you finding that there is a coordination between the different departments and a willingness to work together?

Mr. HORN. Yes. I think that this transfer has been done in the context of cooperation and working together, and I anticipate that that will continue as we move forward with this important program.

REFUGEE SERVICES

Ms. ROYBAL-ALLARD. The U.S. has traditionally been a haven for refugees, but we are seeing significantly reduced numbers of refugees that are being admitted, and I think your budget reflects that particular trend. From your experience in providing services to refugees, do you have any observations about the effectiveness of these services? And, given the current refugee mix, how do you ensure that these services are culturally appropriate so that the refugees can make the transition to living in the United States?

Mr. HORN. I think that there is good reason to believe that the refugee resettlement program is providing effective services that help refugees that come to this country, often not speaking the language, brought into a culture that is often foreign to them, and helping to stabilize them and their families both in terms of their economic stability, but also their family stability, and helping to integrate them into American culture, to at least become familiar with it. And so this is a program that we strongly support. Our budget reflects a level that we believe is sufficient in order to ensure that, with the 70,000 refugee ceiling that has been established by the State Department, we are able to provide the kinds of services that we know can be helpful to this population.

So we feel strongly this is an important program. It is one that needs to be culturally sensitive while at the same time helping ref-

ugees integrate into American culture. I am a psychologist, and it is hard for me to truly get a sense for how difficult it must be to come to a completely foreign culture where you don't speak the language and you are not familiar with the customs. And so this program is very, very effective, we think, and helpful in helping those refugees assimilate.

Ms. ROYBAL-ALLARD. Thank you.

CHILDREN SERVED BY HEAD START

Mr. REGULA. Well, what percent of the students that enter kindergarten and/or first grade go through the Head Start program nationally, total?

Mr. HORN. We serve currently about 60 percent of income-eligible children.

Mr. REGULA. And that represents what percent of the total children entering schools?

Mr. HORN. That I don't have off the top of my head, but I can submit that for the record.

[The information follows:]

CHILDREN SERVED BY HEAD START

We do not have exact data, but we would estimate that, in FY 2002, about 525,000 children leaving Head Start entered kindergarten that fall. Using census data estimates, there were about 3.8 million children who entered kindergarten this past September, so approximately 14 percent of the total children entering kindergarten were Head Start children. However, only 675,000 of the 3.8 million kindergarten children were from low-income families and Head Start served approximately 70 percent of these children.

Mr. REGULA. Do you think the other 40 percent, is it just an absence of aggressive recruiting on the part of communities, or are there communities in the country that just don't have the mechanism, either an agency or something to put on or a school that has any interest in putting on the program?

Mr. HORN. This is precisely the issue that the President seeks to try to address with this new State option in Head Start. When we ask the question about who is served, we start with the program and we say, how many kids are served by this program? And I can give you that answer. But if you ask me instead, of all the low-income 4-year-olds, how many are served in this program, how many are served through State-administered programs, how many are served through child care arrangements, or how many even want to be served. Some of them are at home with their parents. They have a stay-at-home parent who is caring for them. We don't have any mechanism of collecting that information.

STATE PARTICIPATION IN HEAD START

What we do know is that some 42 States currently provide funding for State-administered preschool programs.

Mr. REGULA. How many States?

Mr. HORN. Forty-two.

Mr. REGULA. Forty-two.

Mr. HORN. And all States and territories run child care programs, and yet we don't have any real good idea about how well these three systems are coordinating with each other to provide coverage across this population.

Mr. REGULA. So you are saying that there are States that don't participate in the program on Head Start; am I correct?

Mr. HORN. Certainly there are States that do not contribute to Head Start. Yes.

Mr. REGULA. Okay. They could have a program, but there would not be a State contribution to the program, which means it would have to come in a limited—

Mr. HORN. Exactly.

Mr. REGULA. What percent of the total cost of these programs do you think is State contribution versus Federal?

Mr. HORN. I am sorry. Say that again.

Mr. REGULA. Well, you say the States contribute; I know in Ohio they do. Of the total spent on Head Start, what percent would be coming from the States versus what is coming from the Federal?

Mr. HORN. I don't—

Mr. REGULA. Just trying to get the level of State participation.

Mr. HORN. I am not sure we have that information in that fashion. And it is important to keep in mind that there is the Head Start budget, but other budgets contribute to the services that are provided through Head Start. For example, the medical services and the dental services are routinely paid for through Medicaid, through SCHIP, through PSDDT.

Mr. REGULA. So Head Start identifies this child that needs those services and gets that family in touch with the Medicaid program?

Mr. HORN. There are various ways that they do it, but that is one of the ways they do it.

Mr. REGULA. It seems to me that is very important.

Mr. HORN. Yes.

Mr. REGULA. I think the learning process often depends on health, health and nutrition, and probably there needs to be a lot of emphasis on those two aspects of a child's life.

Mr. HORN. And, in fact, we believe that the President's State option proposal would enhance the ability of Head Start programs to work with these other programs, because these other programs are invariably run by the States. Head Start has a direct Federal-to-local-grantee relationship, and yet Medicaid is run by the States, SCHIP is run by the States, welfare-to-work is run by the States, child care is run by the States. And so we think if the Governor is able to submit a comprehensive plan that can coordinate all of these services, it would actually enhance the ability of Head Start programs to deliver a comprehensiveness of services to the families that they serve.

Mr. REGULA. Ms. Roybal-Allard. Any more questions? We are going to wind this up.

Ms. ROYBAL-ALLARD. If I can submit them.

Mr. REGULA. For the record. Okay.

COMMENTS TO HIGH SCHOOL STUDENTS

I notice we have a lot of students here today. Tell me what is your school? Does anybody want to identify? From Nebraska. I congratulate you on your bravery. The schools in my district are afraid to come to Washington. Are you high school students? This is a senior class trip? A junior class. You raised the money yourselves? And you are all from one school? How many different school dis-

tricts are represented here? How do you get selected now? Each school, you raised individually or as a school group? You arranged money for your trip here, but you are from different States; did I hear you correctly? So you are making new friends. That is not all bad. How long are you here? And when did you arrive? But now that you are here, you are all going to visit different places.

Well, this committee, you might be interested, we appropriate the money for health research, very important to all of you, because your future depends on having cures for things that we don't even know about necessarily now. We appropriate all the money for a Federal portion of education. We appropriate the money for job training, which I hope none of you ever need, at least after you have got a job and that you don't lose your job. And so this committee does a lot of things that are very important in your lives.

And one thing that would be of interest to you, the Health Group and National Institutes of Health, where they do research on all the new ideas and cures for diseases and so on, said that every 5 years life expectancy goes up a year. Now, most of you are, what, about 16? Well, the Bible says you get 3 score and 10, and evidence says you get even more than that; so divide by 5, and you will discover how many more years you are going to get, and that is a pretty good future for you. So what I can only say is, take care of your health. Take care of your health, because if you are going to live those extra years, you want them to be good quality years.

But you are very fortunate to be here. I think you are safe, but there is no guarantees, of course, of anything in life. And yesterday they vacated this building because they found a fire in the elevator, and so everybody is a little jumpy about, as you can see from the security when you tried to get into the place. It used to when I came here we just walk in and out of the building, and there were no concrete barriers, nobody checking your purse or anything else, you just walk in. But we live in a different age, and security becomes important.

But I am glad you are here. I am glad. I wish more students would have the opportunity to come here and observe and visit this city. I hope you will come back with your parents or your family. And now that you will be an expert, you can show your family around.

Are you going to the Smithsonian? I assume you are going to all the monuments. That is great. You are a little braver than the students in my district. They called me and said, will you guarantee that if we come to Washington—that is, the principal—if we bring our students to Washington, that they won't have any problems? I said, hey, wait a minute. I can't give you any written guarantee on that one, but I think it is probably pretty safe. I had one school that has been coming for 30 years and decided not to this year. So you are fortunate really to get here.

We are happy to welcome you in the committee. As you can tell, we are discussing early childhood education, which is important, but education at all levels is important. I hope all of you will plan to get on to a community college or a university. There is no substitute for education, particularly in the age in which we live where most jobs require skills, they require the ability to communicate,

and so on. So make the best of all this year. You are juniors, so you have 1 more year left. And plan for your future.

Well, I am going to recess the committee for about 20 minutes.

COMMUNITY SERVICES BLOCK GRANT AUDITS

Ms. ROYBAL-ALLARD. Mr. Chairman, there was one issue that was just brought to my attention that I would like to ask, if I may.

Mr. REGULA. Go ahead.

Ms. ROYBAL-ALLARD. It has to do, Mr. Horn, again with the Community Services Block Grants. Apparently, there are numerous examples of States not spending their CSBG funding as has been required by law, not all of it or only part of it or not any of it at all. And our report accompanying the fiscal year 2003 bill requested an oversight report from you because the State of California apparently didn't distribute its CSBG for several years. This was before your tenure, I understand, and began at HHS, but it is the State of California, not HHS auditors, that just brought this fact to light. There have been similar findings by HHS itself about the State of Louisiana and the Commonwealth of Puerto Rico.

Ms. ROYBAL-ALLARD. How many of these problems have been corrected? And can you tell me what you are doing to make sure that the Department auditors catch these things and that the ACF enforces the rules and gets remedies implemented by the States?

Mr. WEEMS. Congresswoman, thank you for the question. I don't think we are familiar with the situation. We will look into it and we will get right back to you with an answer and give you the status of the report.

Ms. ROYBAL-ALLARD. I would appreciate that, because my understanding is that California is ready to spend this money and has not been able to.

Mr. WEEMS. We will look into it and get back to you.

[The following questions were submitted to be answered for the record:]

COMMUNITY SERVICES BLOCK GRANT AUDITS

Ms. Roybal-Allard: What is ACF doing to address a problem identified in the State of California regarding their use of unexpended Community Services Block Grant (CSBG) funds recently identified by the State? In addition, there is a new congressional reporting requirement contained in the FY 2003 appropriations committee report regarding State unexpended balances in the CSBG program.

Mr. Weems: Regarding California, I believe the Congresswoman is referring to \$5.1 million in unexpended CSBG funds that accumulated in the State in the early 1990's. These funds were carried forward for several years, and recently, were brought to the attention of the new State leadership, who asked about the allowable use of these funds. The Office of Community Services (OCS) is working with the Office of General Counsel to expedite a decision on the issue of the State's use of these CSBG funds.

We do not anticipate that this problem will be experienced again. Since 1996, language has been included in annual appropriations providing that unexpended funds may be retained by the eligible entities for the succeeding fiscal year. This same language is included in the FY 2004 President's Budget. In addition, OCS is adding language to its Supplemental Audit Guide highlighting the need to closely monitor timely and complete allocation of funds to local entities. For the past two years, we also have requested and received the States' financial report (SF 269) that gives an account of each State's annual obligations, expenditures and balances. As requested in FY 2003 Appropriations Conference Report language, we are gathering data to prepare a report on State carryover balances for the past few years. This information will be provided to the Committee by August 15 as requested.

PRE-LITERACY SKILLS IN HEAD START

Mr. Regula: I have read that many Head Start children leave the program knowing only 2 letters of the alphabet or less. I find this inexcusable for a program that costs over \$6,000 per child. I understand that in the last reauthorization, Congress mandated that children should know at least 10 letters by the time they leave Head Start. How many Head Start children know 10 letters or more at the time they leave the program?

Dr. Horn: Letter recognition is one piece of cognitive development, and research clearly shows us that children who do not take part in cognitive development activities are at risk for school failure. This is what the Bush Administration hopes to work with Congress to address by strengthening Head Start through reauthorization.

Over the past two years we have increased our efforts to help Head Start programs enhance school readiness and the development of early literacy skills. In April 2002, the President announced his *Good Start/Grow Smart* initiative which is designed to assure that every Head Start teacher has the training skills they will need to provide Head Start children the early literacy, language, and numeracy skills they will need to be successful in school.

More needs to be done. We do not know how many Head Start children know 10 letters or more when they leave Head Start but we do know have information on the average number of letters children know when they enter and leave the program.

Children entering Head Start in 1997 learned the equivalent of 4 additional letters, and knew an average of 7.2 letters at the end of the year. The national sample that entered Head Start in the fall of 2000 showed greater gains in letter recognition. Their scores meant that children learned the equivalent of 5 additional letters in Head Start and knew an average of 8.9 letters at the end of the program year.

Mr. Regula: How does this compare with the letter awareness and vocabulary of children in other preschool programs or children who are less disadvantaged?

Dr. Horn: Although children make gain toward national averages during the Head Start year, especially in vocabulary and early writing skills, they leave Head Start still below national averages. The Bush Administration would like to see the Head Start program do better.

There are no national data on how many letters of the alphabet the average preschooler can identify by name. One proxy is provided by the Woodcock-Johnson Letter-Word Identification sub-test, which has nationally-normed data on a sample of children across all income groups. On that measure, children are shown 9 letters of the alphabet which vary in difficulty, as part of a continuum of tasks associated with decoding skills. In FACES 2000, in relation to national norms on the Letter-Word sub-test, Head Start children advanced about as much as the "typical" preschool-age child,

and performed better than the 1997 FACES cohort where Head Start children did not advance as much as the "typical" preschool-age child.

FACES found that vocabulary standard scores increased about 4 points or .26 of a standard deviation from fall to spring in both FACES 1997 and FACES 2000. Early writing standard scores showed similar increases in FACES 1997, slightly less in FACES 2000. Nonetheless, at the end of Head Start, children trail national norms in these measures by 2/3 to nearly a full standard deviation.

Mr. Regula: How have the Head Start programs changed in response to the Congressional-mandate regarding the 10 letter recognition?

Dr. Horn: The Bush Administration has placed a far greater emphasis on the importance of strengthening early literacy and numeracy skills for children in Head Start. Specifically, in responding to the President's Good Start, Grow Smart initiative, the Head Start Bureau has undertaken a number of efforts aimed at bolstering the school-readiness of Head Start children. The Strategic Teacher Education Program, known as STEP, launched last summer, was designed to ensure that every Head Start program and every classroom teacher has a fundamental knowledge of early development and literacy, and of state-of-the-art early literacy teaching techniques. Good Start, Grow Smart calls for not only the improvement and strengthening of Head Start through intense, large-scale efforts in the areas of early language and literacy, but also for a method to track the results of this effort. This fall we will begin implementing the Congressionally mandated assessments of the school readiness of all the four-year old children in Head Start.

Mr. Regula: What else is the Administration proposing to increase the pre-reading skills and reading readiness of these children who are at greatest risk for future educational failure?

Dr. Horn: The President has proposed a variety of activities to increase school readiness for Head Start children. As part of the President's 2004 budget request, and in the *Strengthening Head Start* policy book, we proposed to allow Governors the option of coordinating Head Start in their state, or portion of their state, with other early childhood and pre-K programs. We believe that by allowing states the choice to coordinate these programs, we will see an increased focus on school readiness. States are already being held accountable for children being able to read on grade level by the 3rd grade. Research clearly shows that the earlier children begin taking part in scientifically sound early cognitive development activities, the higher the likelihood they will be performing at grade-level by 3rd grade. States should have the ability to align their pre-K programs and Head Start programs with kindergarten and elementary school expectations. This in no way means that they should be able to cut back on the other services provided to Head Start children. Rather we would require that they show us how they intend to do both.

In addition, last year, the President launched *Good Start, Grow Smart*, a school readiness initiative that calls for:

- (1) An accountability system for every Head Start center in America.
- (2) A major effort to prepare Head Start teachers. Through Project STEP, we have trained nearly 3,000 Head Start teachers, giving them the tools necessary to teach basic skills to our children. These teachers will then instruct Head Start teachers around the country.
- (3) We have distributed more than 500,000 guidebooks for early childhood educators and care givers. It's called, "Teaching Our Youngest." It contains proven teaching activities to help children develop their language abilities, increase their knowledge, and discover a love of books and reading and learning.
- (4) And as you know, and with your help, HHS has distributed a series of pamphlets to more than 1.5 million parents about child development called "Healthy Start, Grow Smart" based on the best scientific research that gives suggestions on child development at crucial early stages of a child's life.

The Head Start Bureau has put out invitations for applications for some interesting activities as well: (a) The Early Childhood Educator Professional Development Program, is intended to enhance the school readiness of young children, particularly disadvantaged young children, and to prevent them from encountering difficulties once they enter school. The program is designed to improve the knowledge and skills of early childhood educators who work in communities that have high concentrations of children living in poverty, and (b) Abstracts are invited from organizations for Innovation and Improvement Projects that address the President's initiatives related to the Head Start (including Early Head Start) program.

Finally, we also are placing increased emphasis on children's academic skills as part of our on-site monitoring efforts. We are continuing to place emphasis on assuring programs are hiring qualified, well trained classroom staff that have the skills necessary to help prepare children for school. We are, in short, making school readiness and all that it may entail, including, of course, early literacy skills, an ever more important part of a child's Head Start experience.

TESTING IN HEAD START

Mr. Regula: I understand that this Administration plans to require some new testing for Head Start children beginning this Fall. Can you describe this proposal and how it will be implemented?

Dr. Horn: This fall we will begin implementing the Congressionally mandated assessments of the school readiness of all four-year old children in Head Start. In developing this outcomes-oriented system, we are working with a technical workgroup that advises and guides our selection, development, and use of reliable and valid measurement tools. Assessment items are currently being recommended for inclusion in the proposed field-test.

Mr. Regula: What is the proposed cost of this testing? Does your FY 2004 budget include sufficient resources to cover the cost?

Dr. Horn: Because planning is still under way, we are not able to project exact costs. However, we estimate total costs for development and implementation of testing to be \$22 million, including contract costs for the development and testing of the system and for training staff, and staff time in local programs to attend training and conduct assessments and report the findings. There are sufficient funds in the Head Start budget to cover these costs.

Mr. Regula: How will the results of these tests be used? Will the results be individualized, and available to parents?

Dr. Horn: Information from the assessments will be used in several important ways. It will increase our understanding of local program effectiveness, giving us a critical and currently missing building block for improving the program. It also will help guide the use of training and technical assistance resources, allowing us to understand which strategies are working most and least effectively in preparing Head Start children to enter school with a solid foundation of skills and abilities.

The national reporting system will not analyze data at the level of individual children nor communicate information back to parents about their child. However, information concerning outcomes at the program level will be available for parents to consider.

Mr. Regula: Will all children be tested? If not, how will children be selected?

Dr. Horn: All Head Start children will be assessed in the year before they leave Head Start to enter kindergarten. This will involve approximately 525,000 children, mostly four-year-olds, of the total 912,000 children Head Start serves.

Mr. Regula: Will this be a pass/fail test for a child to get into kindergarten?

Dr. Horn: No. The assessment initiative is not in any way intended to test individual children for school readiness. The data will be used to improve services at the program level.

Mr. Regula: How will you ensure that this testing won't be used inappropriately to drill students without a larger learning context or used to put too much pressure and stress on these children's little bodies?

Dr. Horn: The assessment of individual children will involve a short period of time, perhaps 15 to 20 minutes, in the spring and fall. Great care will be taken to insure that it is not an unduly stressful experience for children. We do not intend for programs to concentrate teaching, time and activities on the indicators being assessed to the exclusion of opportunities for children to learn and develop, in physical, social-emotional, creative arts, science and other areas of cognitive development. Programs will continue to be held accountable for implementing comprehensive, locally selected curricula as mandated by the Head Start Performance Standards. We intend for every program to provide daily opportunities for all children to engage in early literacy, language and numeracy activities, group experiences and individual activities which are guided by teachers. Guided by observations and local ongoing assessment of children, teachers should be designing and adapting activities and interactions with children to support their learning and growth. The national reporting system will provide a new tool to document the quality and outcomes of these efforts on a consistent basis across classrooms, centers and programs.

RESEARCH ON HEAD START

Mr. Regula: What does recent research, such as that collected through the Head Start Family and Child Experiences Survey (FACES) indicate about the program?

Dr. Horn: The Head Start Family and Child Experiences Survey (FACES) is an ongoing, longitudinal study of Head Start program quality and child outcomes, which currently has two nationally representative cohorts (1997, 2000) and plans for a third. FACES provides important information on program quality over time, and child outcomes from program entry through kindergarten follow-up. FACES uses a sample of classrooms, children, and families that is scientifically representative of all Head Start programs. Although FACES does not include a comparison group and therefore cannot be used to estimate the effectiveness of Head Start, it does provide evidence of differential strengths in Head Start programs.

Based on FACES, Head Start has achieved overall, good program quality as measured by an observational measure of classroom and center characteristics. Head Start gets very high ratings of satisfaction from parents. Gains occur across the Head Start year in vocabulary and writing skills. For the roughly 16 percent of children in Head Start with a suspected or diagnosed disability, 80 percent of parents reports that Head Start had helped them obtain special needs resources for the child.

Yet, we have not seen as much progress as we would like in activities designed to prepare these children for success in school. Development of pre-reading skills such as letter recognition or book knowledge, or enhanced numeracy skills over the course of the Head Start year showed little progress. These findings show that children enter

Head Start with skills that are substantially below national averages and although they make gains toward national averages during the Head Start year, especially in vocabulary and early writing skills, they leave Head Start still below national averages. Children also show progress in letter recognition and early math skills, but not advance against national averages. Moreover, no reduction in the frequency of problem behaviors, such as aggression, was shown.

Mr. Regula: What do we know about the Head Start program and how it affects children's learning in the long run (beyond 1st or 2nd grade)?

Dr. Horn: While the Head Start FACES study and the Head Start Impact Study do not follow children beyond first grade, we know from research on related, intervention programs, that children can experience long-term benefits, including less need for special education services, and less frequent retention in grade. The Head Start/Public School Transition Demonstration Evaluation found that Head Start graduates who were enrolled in elementary schools of relatively good quality experienced growth in such areas as early literacy and math skills and reached the national average by third grade.

Into Adulthood: A Study of the Effects of Head Start, directed by High/Scope Educational Research Foundation, presents encouraging findings from a 17-year follow-up study of 622 young adults 22 years old in Colorado and Florida, who were born in poverty and did or did not attend Head Start as young children. The researchers located and interviewed 77 percent of the original sample of children. The study found evidence of important effects of Head Start on school success and crime. For females (but not males) at one study site after adjusting for background differences, only about one-fourth as many Head Start participants as non-participants (5% versus 19%) failed to obtain a high school or GED diploma, and only one-third as many (5% versus 15%) were arrested for crimes.

Since no studies to date have followed samples of children who were assigned to receive Head Start services on a random, scientific basis, these conclusions are not as firm as we would like. But research does tell us a great deal about the skills and knowledge children need to be successful in school. In addition, effects of small-scale, high-quality early education programs show unequivocally that high-quality infant and preschool programs can produce large and lasting benefits.

Given this research, President Bush believes Head Start must provide more emphasis on early learning and promote the best methods for preparing children for success in school by making early education a top priority.

HEAD START QUALITY

Mr. Regula: Is the quality of Head Start improving?

Dr. Horn: The observed quality of Head Start classrooms consistently averages in the "good" range using standardized measures. In addition, FACES 2000 has found that Head Start teachers have higher levels of educational attainment than teachers studied in 1997-1998. In FACES 2000, Head Start children are scoring higher on assessments of letter recognition and book knowledge, areas in which they lagged in 1997-1998.

Mr. Regula: Are children progressing in certain areas of development, and if so, what?

Dr. Horn: The FACES study allows comparisons of scores with national averages for children of all income levels. Head Start children make significant progress, greater than that of typical same-age peers of all income levels, in the areas of vocabulary and early writing. For example, English proficient children in FACES 2000 gained 3.8 points in standard scores from 85.3 to 89.1. Methodologists have called such gains "educationally meaningful" and they are greater than the gains made by the typical child of this age, regardless of income level. However, they do not raise Head Start children to the national average in vocabulary scores. Adding in children who were not proficient in English on entry into the program, the average standard score in vocabulary changes from 81.4 to 85.7, representing a gain of 4.3 standard score points over the 2000-2001 year. Children enter Head Start with vocabulary scores that are at about the 16th percentile nationally.

In another important literacy area, pre-writing, Head Start children make significant gains relative to national norms (in FACES 2000, 85.1 to 87.1, 2 points, but are still below national averages. This gain in early writing is slightly smaller than that seen in FACES 1997.

Head Start children in FACES 2000 are making more progress in the area of letter recognition than they did in 1997-1998. Their scores meant that children learned the equivalent of 5 additional letters in Head Start and knew an average of 9 letters at the end of the program year. In relation to national norms on the Letter-Word sub-test, Head Start children advanced about as much as the typical preschool-age child, and performed better than the 1997 cohort.

Book and print concepts do not have national norms available, but in FACES 1997, children did not show advances in this type of knowledge from fall to spring. By contrast, in FACES 2000, mean scores showed a significant gain, from 1.61 in the fall to 2.46 in the spring.

Mr. Regula: Are there areas that continue to lag, and if so how do we improve these?

Dr. Horn: Significant improvement is needed in children's early literacy skills. In general, Head Start children enter the program with scores far below national averages. While they make progress during the program greater than that of the typical child of their age in such key areas as letter recognition, early writing, and vocabulary, they still leave the program with scores lower than the national averages.

Improving early literacy skills is an important priority for the Department and the Administration. We are focusing local Head Start programs' attention on the important academic areas of early literacy and early math that needed to be strengthened. The Head Start Child Outcomes Framework has established a clearer set of expectations for early childhood curricula in Head Start. Programs also are devoting more attention to the ongoing assessment of children's progress. Locally, Head Start programs are assessing children's progress in the areas mandated by Congress, including alphabet knowledge, phonemic awareness, numeracy, and book handling skills. We also are launching a new national reporting system in the fall of 2003 to systematically track children's progress in a number of these key areas

In the summer of 2002, we launched Project STEP, an intensive professional development effort to assure that every Head Start teacher has the knowledge to assure that children achieve the desired skills and outcomes regarding early literacy. Continuing support is being given to teachers through an extensive network of skilled, early literacy mentor-coaches. Efforts also are continuing to improve the education and qualifications of Head Start teachers. In 2002, 51 percent had a college degree in early childhood education or a related field, already meeting the congressional mandate that at least 50 percent of teachers have such a degree by the end of fiscal year 2003.

INFORMATION DISSEMINATION TO AT-HOME CHILD CARE PROVIDERS

Mr. Regula: We are discovering so much information about how children learn and the importance of providing a literacy-rich environment in the early years and bringing this element into federally-funded child care programs. How do you get information about early learning into the hands of parents who care for children in their own homes?

Dr. Horn: I agree that it is critical for this information to reach all caregivers of young children. Scientific research clearly demonstrates that parents and early care and education providers can use specific activities to prepare children for school. We need to help parents and caregivers understand the steps they can take to guide children effectively toward successful vocabulary development, pre-reading and numeracy skills.

Under his *Good Start, Grow Smart* initiative, President Bush tasked the U.S. Department of Education (ED) with providing parents, teachers, and caregivers with information on early learning. In response, last year ED, with support from the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) developed and distributed, in hard copy and online, a series of easy-to-understand informational booklets for parents called "Healthy Start, Grow Smart." This

series is modeled after materials that were developed as an initiative of Laura Bush as the First Lady of Texas and sponsored by the Texas Department of Health. The thirteen booklets provide information on ways to assure the health, safety, nutrition, and cognitive development of children during their crucial first year. The U.S. Department of Education has developed additional informational materials targeted to parents, including "Helping Your Preschool Child" and "Helping Your Child Become a Reader." HHS has promoted and distributed these materials, for example, through its National Child Care Information Center (www.nccic.org).

The HHS Child Care Bureau (CCB) has been charged with implementing other aspects of the *Good Start, Grow Smart* initiative, including work with States to develop early learning guidelines, professional development plans, and collaboration plans. With these efforts, the Child Care Bureau is addressing the whole spectrum of child care providers, including unregulated, informal care provided by family, friends, and neighbors. CCB is designing its entire technical assistance effort, including a recent series of regional planning workshops, to meet the needs of the spectrum child care settings and providers.

While promoting cognitive and literacy skills is an essential part of preparing children for school, we also need to ensure that they are emotionally and socially ready. The Child Care and Head Start Bureaus have jointly funded a Center for the Social and Emotional Foundations for Early Learning. The Center has developed a series of "What Works Briefs" that provide easy-to-read, "how-to" information on evidence-based practices that promote social and emotional development for young children that can be applied in a variety of settings--from classrooms to homes. The briefs are available online at: www.csefel.uiuc.edu.

As we develop resources, the Child Care Bureau is looking at new ways of disseminating information. The CCB is beginning to partner with a number of networks that reach parents and other caregivers, including Agriculture's Cooperative Extension Service and Education's Ready to Learn Television. The CCB funds Child Care Aware, a website and hotline that helps families find child care, but also includes parenting information. At the local level, child care resource and referral agencies, most of whom receive funding through the Child Care and Development Fund (administered by CCB), disseminate information on a variety of topics, including early learning. Effective dissemination will involve a variety of stakeholders that interact with families, including libraries, pediatricians, health departments, and faith-based organizations.

MONTGOMERY COUNTY MARYLAND PRESCHOOL PROGRAM

Mr. Regula: I recently read an article in the Washington Post which described how Montgomery County, Maryland is abandoning the traditional Head Start program in favor of a new locally-developed preschool program. Are you familiar with this situation, and can you tell the Subcommittee more about why Montgomery County is making this change?

Dr. Horn: Montgomery County, Maryland has been a Head Start grantee for many years. It, like all other Head Start grantees, is required to match federal grant funds at a rate of 1 local dollar for every \$4 in Federal Head Start monies. Montgomery County, in fact, has for years exceeded that requirement and the extra funds made available by the county were used to serve several hundred more children in Head Start than would have otherwise been possible. Montgomery County was considering reducing its non-federal match to the required minimum and using the remaining county funds to provide an early childhood program to the county's low-income children that would have focused on education but would not have included many of the other component parts of Head Start such as social services, health, nutrition, etc.

It is my understanding that the county has decided for now not to pursue this and will continue to make available county funds to serve children in a comprehensive Head Start program.

Mr. Regula: What sort of things they are including in their new preschool program that differ from what they did under the Head Start authority?

Dr. Horn: It is my understanding that their program would have been focused on early childhood education and not included other services that are provided by Head Start grantees including health, mental health, nutrition, etc. It would have operated for only 2 1/2 hours per day.

Mr. Regula: How does the cost per child compare with the Head Start program?

Dr. Horn: The cost per child for the Montgomery County Early Childhood Education program was estimated by the county to have been approximately \$2,700 per child. Head Start's average per child costs, in FY 2002, was \$6,711.

Mr. Regula: How are they funding this new program?

Dr. Horn: They would have used the excess "match" funds that were allocated to their Head Start grant.

CHILDREN WITH DISABILITIES

Mr. Regula: We know that children with disabilities can make dramatic gains in terms of cognitive and social development if needs are identified early and quality intervention is provided. How does the Head Start program train teachers to identify potential development problems early on?

Dr. Horn: Head Start and Early Head Start programs work with families and community partners to enable the early identification of child development problems. For many children, enrollment in Head Start provides the first indication that a disability or health condition may be affecting their development. Each program must plan and implement a sound, systematic approach for developmental screening and ongoing

assessment of children's development. This screening and assessment system must include the careful selection and administration of instruments and procedures and the competent interpretation of results. Head Start programs must assure that screenings and assessments are conducted by appropriately trained individuals. In addition to the work of Head Start teachers and staff, some of the screening (e.g., vision screening) may be conducted through agreements with community partners from local special education/early intervention, health, and mental health agencies. To help families acquire services more quickly, and to reduce duplication of efforts, Head Start and Early Head Start programs work collaboratively with the Local Education Agency and the Early Intervention agencies in their communities to identify and serve young children with disabilities.

For some children, the results of screening procedures, combined with information available from the ongoing assessment of their progress, may indicate the need for referral for a formal evaluation by a professional. The formal evaluation, utilizing multiple sources of information from the family and program (including the ongoing developmental assessment of the child) will more fully assess the child's status, and determine what intervention may be needed. (e.g., special education or related services).

Mr. Regula: How are these teachers trained to provide the sorts of early interventions that are critical to the child's future success?

Dr. Horn: Head Start and Early Head Start programs must provide teachers with the training, supervision and support they need to address the objectives outlined in the individualized plan (IEP/IFSP) for each child with a disability. To accomplish this, the special education teachers and/or therapists (typically employed by the local education or early intervention agency) provide special services in the Head Start/Early Head Start setting, including regular consultation with the Head Start teachers. This consultation focuses on how to support children's progress on individualized objectives during their participation in the Head Start program's daily activities

In addition to the training, supervision, and support that Head Start teachers receive to implement educational plans for children, Head Start programs provide training to all staff on more general issues of serving children with disabilities and their families. This training often utilizes resources available from their local and state-level special education partners. The Head Start Bureau also provides information, training and technical assistance that supports the inclusion of children with disabilities.

HEAD START BUDGET REQUEST

Mr. Regula: What specifically will the increase requested in Head Start for fiscal year 2004 be used for?

Dr. Horn: The President's proposed FY 2004 budget requests an increase in Head Start funding of \$148 million which will be used to award a 2.2 percent funding increase for each grantee to offset inflationary increases and maintain competitive

salaries for teachers. In addition, the budget proposes to reallocate approximately \$68 million in training and technical assistance funds which would be used to increase Head Start enrollment by approximately 10,500 children in those areas of the country with the greatest unmet need for Head Start services. The use of funds in this manner is dependent on enactment of the Administration's proposed reauthorization package.

Mr. Regula: Does the President's request include sufficient funding to carry out the quality improvements required by the Head Start statute?

Dr. Horn: There is no specific quality improvement funding, as defined in Section 640 of the Head Start Act, included in this request. Such funding does not happen unless any given fiscal year's appropriation exceeds the previous year by more than the rate of inflation. The President's request is equal to the expected rate of inflation. However, the President's proposed budget does allow programs to increase staff salaries and benefits by 2.2 percent and, in so doing, allow programs to attract and retain qualified staff.

In addition, Head Start grantees have received significant increases in quality funding in the last few years which will enable them to continue providing high quality services to Head Start children and Families. For example, in one of the more important quality improvements mandated in the Head Start Act, grantees have increased the percentage of Head Start teachers with qualifying college degrees from 37 percent in 1999 to 51 percent 2002.

Mr. Regula: What does the request include in terms of services for Early Head Start?

Dr. Horn: The FY 2004 request proposes an increase in Early Head Start funding of 2.2 percent, or \$14.8 million. These funds will be used to allow Early Head Start grantees to offset inflationary increases and maintain competitive salaries for teachers and other Early Head Start staff. Under this budget request approximately 62,000 children will receive Early Head Start services, the same number of children as provided in the FY 2003 budget.

Mr. Regula: What cost of living increase is included for Head Start in the President's request?

Dr. Horn: The President's budget proposes a cost-of-living increase of 2.2 percent.

INDEPENDENT LIVING TRAINING VOUCHERS

Mr. Regula: A significant increase has been requested for the independent living training vouchers program. Why such a large increase for a program that is just beginning in fiscal year 2003?

Dr. Horn: The proposed budget request for FY 2004 of \$60 million is the same as the FY 2003 request. In FY 2003, the Education and Training Vouchers Program was appropriated at about \$42 million less a recision of .65 percent. The FY 2004 budget request restores support for this program to the original full authorization level.

The full authorization would allow us to continue supporting State efforts to meet the needs of this highly vulnerable population. These vouchers would provide youth an additional resource to prepare for adult living, increasing the prospect that they will be able to secure work and become contributing members of society.

Mr. Regula: How does this program work?

Dr. Horn: States are awarded funds annually based on the ratio of the number of children and youth in foster care in a State to the national total of those in care. With these funds, States can provide vouchers of up to \$5,000 per year to each youth eligible for post secondary educational and training assistance. The vouchers cover expenses such as tuition, books, fees, uniforms, equipment, and other allowable costs related to attending college, vocational school or other accredited educational institutions.

States are responsible for establishing specific guidelines for determining the application procedures for the award of the educational and training vouchers. They also are responsible for conducting outreach to identify and inform potentially eligible youth. Caseworkers work with youth in care to develop and implement educational plans geared toward successful completion of high school and preparation and admission into post secondary education and training institutions to ensure readiness.

Mr. Regula: For what types of services can a child who receives a voucher use it?

Dr. Horn: States have the flexibility and resources to implement, expand and strengthen the voucher program to meet the needs of those eligible youth within their jurisdictions. The vouchers can cover expenses such as tuition, books, fees, equipment, and supplies, uniforms and other related costs associated with attending college, trade school or other accredited educational institutions. A youth also may use the voucher for services including, but not limited to, tutoring, mentoring, housing and school-related travel.

Mr. Regula: What statistics are there about the numbers of children that are eligible for these vouchers? Without the voucher program, what percentage of children leaving foster care go on to receive either a college education or technical training post-high school?

Dr. Horn: We estimate approximately 20,000 youth age out of foster care each year. The majority of these youth, as well as youth adopted after age 16 are eligible to participate in the voucher program. Also, it is likely that there are twice as many former foster care youth under age 21 who need assistance to enter and successfully complete

some form of post-secondary education or training. According to the law, they also would be eligible to receive assistance under the program.

Presently, we have no definitive national data about the educational outcomes for youth in foster care. However, recent surveys, testimony from the youth themselves and a few small studies indicate that the overall educational outcomes for this population leave a lot to be desired. Too many of these youth have not finished high school or obtained a GED (general equivalency diploma). According to the National Foster Care Coalition, students in out-of-home care are 57 percent less likely to complete high school compared to their peers in the general population. With few exceptions, the prospect of these youth going on to post-secondary education and training is even more dismal. We expect that the opportunities for post-secondary education financial support will provide an incentive for foster care children to complete high school and go further in their education.

Mr. Regula: What kinds of goals have been created to assess the performance of this program?

Dr. Horn: We are developing a national data base containing outcome measures, indicators and data elements, including those specifically related to the educational status and attainment of youth in foster care and those aging out of care. The national database has been developed as a result of an extensive consultation process mandated by the Foster Care Independence Act of 1999. The Act authorized the development of outcome measures that could be used to assess the performance of States in operating independent living programs; and to identify data elements needed to track the characteristics of youth served and the services they receive. We will implement a uniform reporting system through regulation and use the data reported by States for analysis and reporting purposes.

COMMUNITY SERVICES BLOCK GRANT

Mr. Regula: There is a \$151 million reduction for the Community Services Block Grant program. According to the budget justification the rationale for the reduction is a lack of strong performance data. Please tell us about the proposals to improve this program.

Dr. Horn: The President's budget proposes to strengthen program accountability in reauthorizing the Community Services Block Grant (CSBG). Under the proposal States would be required to ensure that all Community Action Agencies and other organizations administering CSBG assess their program outcomes. Organizations that are not performing at an acceptable level may lose their designation as a service provider if corrections are not made. A state-run competition would be held to designate a new organization to replace the agency that has failed to meet performance outcomes.

The Administration is working collaboratively with State CSBG authorities and local eligible entities to identify approximately 10 to 12 national performance indicators for the CSBG program. Most of the outcome measures being considered are those for which data are now being collected from a majority of States and eligible entities through "Results Oriented Management and Accountability," or ROMA. ROMA has been a bottom-up, mostly voluntary, process over the past nine years to install performance-based systems among States and local agencies receiving CSBG funding. By making these outcome measures mandatory, as part of the CSBG reauthorization, more consistent data can be collected and an analysis of effectiveness can be conducted for each grantee.

PROMOTING SAFE AND STABLE FAMILIES

Mr. Regula: Over the past two years the Administration has requested significant increases for the discretionary portion of the Promoting Safe and Stable Families program. This year that increase is over \$100 million, doubling the program from the 2003 enacted appropriation. What is the rationale for this increase?

Dr. Horn: Legislation was enacted in November, 2002 to reauthorize this program through FY 2006 and increase the authorization to \$505,000,000 for each year. The new law authorized mandatory funding of \$305 million for FY 2002 through FY 2006 with the existing set-aside amounts. The law also authorized additional discretionary funding of \$200 million for FY 2002 through 2006. From any discretionary funding, the law provides a 3.3 percent set-aside for evaluation, research and technical assistance, a 3.3 percent set-aside for State Court Improvements and a 2 percent set-aside for grants to tribes. By increasing the funds for Safe and Stable Families programs and supporting more preventive efforts to help families in crisis, the prospect of children living in a safe and permanent homes is enhanced.

Mr. Regula: What services are provided through this program?

Dr. Horn: This program requires States to spend a significant portion of their funds on four types of programs meant to either keep families together or to expedite permanency for children.

- Family preservation services are services designed to help families alleviate crises; maintain the safety of children in their own homes; support families who are preparing to reunify or adopt, and assist families to obtain services and other support necessary to address their multiple needs in a culturally sensitive manner. The definition was amended in the recent reauthorization to allow States to support infant safe haven programs.
- Family support services are primarily community-based preventive activities designed to promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children; enable families to use other resources and opportunities available in the community; create supportive networks

to enhance child-rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families; and strengthen parental relationships and promote healthy marriages.

- Time-limited reunification services are provided to a child that is removed from home and placed in foster care and to the parents or primary caregiver. These services are available only during a child's first 15 months in foster care in order to facilitate the safe and timely reunification of the family.
- Adoption promotion and support services are designed to encourage more adoptions out of foster care when adoptions promote the best interests of the children. They include pre- and post-adoption services designed to expedite the adoption process and support adoptive families.

A few of the many examples of how States use these funds include:

- the establishment of community Family Resource Centers where parenting classes, or supervised visitation or other services occur;
- contracting with adoption agencies to recruit families;
- mental health and substance abuse help;
- respite care; and
- transportation.

MENTORING CHILDREN OF PRISONERS

Mr. Regula: The fiscal year 2003 appropriation included nearly \$10 million to fund the first year of a new, Mentoring Children of Prisoners program. The budget request for 2004 is five times that amount, \$50 million. What is the rationale for such a significant increase particularly when the program is just getting started?

Dr. Horn: Approximately 2.1 percent of all children in the United States has a parent in Federal or State Prison -- almost 2 million children. The President is committed to supporting the training and recruitment of a cadre of mentors to serve as positive role models for more than 6,000 children of incarcerated persons with the FY 2003 appropriation of \$9.9 million. The \$40 million increase in the Mentoring Children of Prisoners Program will allow an additional 26,000 children and families to be served.

Mr. Regula: Have there been positive responses to the new program?

Dr. Horn: Yes, we have received numerous inquiries about the program from community and faith based entities as well as States and local governmental agencies, in anticipation of release of the grant announcement.

Mr. Regula: What kinds of programs and services will be provided to these children?

Dr. Horn: We expect to receive numerous applications for the Mentoring Children of Prisoners Program, proposing to provide a wide array of mentoring strategies and services. We expect the mentors to be adults who, with parents, will provide young people with support, counsel, friendship, reinforcement, and a constructive example. The mentors will be good listeners; people who care, who want to help children and youth bring out the strengths that are already within them.

Mr. Regula: Does the program seek to attain the involvement of the parent who is incarcerated and other family members, if so, how?

Dr. Horn: Yes, according to the Bureau of Prisons there is evidence to suggest that inmates who are connected to their children and families are more likely to avoid negative incidents and have reduced sentences. Grantees will be expected to work with the appropriate corrections officials in order to make sure that the entire family is actively engaged in the mentoring process. This will be done through visits, phone conversations or letters when appropriate. The program will also be designed so that when appropriate the reunification of the incarcerated parent and the family will be a natural one with realistic expectations.

COMPASSION CAPITAL FUND

Mr. Regula: Please tell us about the types of activities that are being funded through the Compassion Capital Fund and define for the Committee and give an example of an "intermediary organization" that would receive a grant under this program.

Dr. Horn: An intermediary organization serves as a bridge between the federal government and small faith-based and community organizations that the CCF program is designed to assist. Intermediaries assist these small groups, for example, in their efforts to improve effectiveness and organizational management, access funds from diverse sources and manage those funds, develop and train staff, expand the types and reach of social services programs in their communities, and develop promising collaboration among organizations dedicated to social service delivery.

Examples of CCF Grantees:

Associated Black Charities, a Baltimore-based intermediary, offers a wide range of training, technical assistance, and sub-awards to faith-based and community organizations providing social services in Baltimore and select Maryland counties. Associated Black Charities, in collaboration with community and university partners, will build the capacity of participant grassroots organizations so that they may strengthen social service delivery to individuals, families, and communities.

Montana State University, Montana Office of Rural Health, in Bozeman, Montana, has collaborated with 15 health organizations throughout Montana, including Blue Cross Blue Shield of Montana, Lutheran Social Services, the Parish Nurse Center of Carroll College, the Montana Association of Jewish Communities, and the Montana

Hospital Association to offer a wide range of capacity-building assistance to faith-based and community health service organizations, including organizations serving Native Americans.

Nueva Esperanza, a faith-based community economic development corporation with a history of service to Latino communities, is offering technical assistance, training, and sub-awards to Latino organizations to increase their capacity to serve their communities. In the first year of the program, Nueva Esperanza will assist organizations in Southern California, Southern/Central Florida, the Delaware and Lehigh Valleys/Southern New Jersey region, and Seattle.

Father Joe's Villages, based in San Diego, CA, is a nationally renowned model for the provision of comprehensive and integrated social services to the homeless. Father Joe's project will offer training and sub-awards to faith-based and community organizations to assist in building collaborations and networks of organizations, and will disseminate best practices in the area of homelessness services.

Volunteers of America, a national faith-based organization with a history of social service delivery, is offering training, mentoring, and sub-awards to organizations helping the poor in the Greater Cincinnati metropolitan area and the Mississippi-Alabama coast area. Volunteers of America is developing its program to serve as a replicable model for other intermediaries to follow in their service to faith-based and community organizations in their communities.

PROMOTING RESPONSIBLE FATHERHOOD AND HEALTHY MARRIAGE

Mr. Regula: The budget request includes \$20 million in funding for the Promoting Responsible Fatherhood program again this fiscal year, but it is still an unauthorized program. What is the status of that legislation?

Dr. Horn: The legislation is incorporated into section 119 of HR 4, which passed the House on February 13th. It also is included in S 5, which has been introduced into the Senate and referred to the Senate Finance committee.

Mr. Regula: What are the details of the program? How will this program work?

Dr. Horn: The program would be funded at \$20 million a year, for fiscal years 2004-2008, providing three kinds of grants with varying matching requirements:

1) Full service grants must address all four objectives of the program, as follows:

- Promoting responsible, caring, and effective parenting through counseling, mentoring, and parenting education, dissemination of educational materials and information on parenting skills, encouragement of positive father involvement, including the positive involvement of nonresident fathers, and other methods.

- Enhancing the ability and commitment of unemployed or low-income fathers to provide material support for their families and to avoid or leave welfare by assisting them to take full advantage of education, job training, and job search programs, to improve work habits and work skills, to secure career advancement by activities such as outreach and information dissemination, coordination, as appropriate, with employment services and job training programs, including the One-Stop delivery system established under title I of the Workforce Investment Act of 1998, encouragement and support of timely payment of current child support and regular payment toward past due child support obligations in appropriate cases, and other methods.
- Improving fathers' ability to effectively manage family business affairs by means such as education, counseling, and mentoring in matters including household management, budgeting, banking, and handling of financial transactions, time management, and home maintenance.
- Encouraging and supporting healthy marriages and married fatherhood through such activities as premarital education, including the use of premarital inventories, marriage preparation programs, skills-based marriage education programs, marital therapy, couples counseling, divorce education and reduction programs, divorce mediation and counseling, relationship skills enhancement programs, including those designed to reduce child abuse and domestic violence, and dissemination of information about the benefits of marriage for both parents and children.

2) Smaller limited purpose grants of up to \$25,000 per grant would only be required to address 1 of the 4 objectives.

3) Two Multicity/State Demonstration Projects will be funded and must meet all 4 objectives of the full service grants. Eligible entities for these grants are national non-profit fatherhood promotion organizations with experience in multicity/state and government coordination.

Mr. Regula: What kinds of entities would receive funding under this proposal? States? Community- and faith-based organizations?

Dr. Horn: Public and non-profit community entities, including religious organizations and Indian tribes and tribal organizations, could receive funding under this proposal.

Mr. Regula: Are there States or communities that have successful programs that this federally sponsored program is modeling? If so, please describe those programs?

Dr. Horn: There have been two major multi-state/site demonstrations of responsible fatherhood programs with evaluations documenting effectiveness.

The first group of projects called "Parents Fair Share" was demonstrated from 1994-1996 in Dayton, Ohio; Grand Rapids, Michigan; Jacksonville, Florida; Los Angeles, California; Memphis, Tennessee; and Springfield, Massachusetts and evaluated by Manpower Development and Research Corp (MDRC). The final evaluation (November 2001) concluded:

- The program increased employment rates and earnings for the most disadvantaged men.
- Fathers' involvement with their children was most increased for those with low initial levels of contact.
- Fathers that were brought in for eligibility screening increased child support payments.
- Fathers found eligible for the program increased their child support payments.

The second group of multi-state/site responsible fatherhood programs, called the Office of Child Support (OCSE) Fatherhood Programs, was conducted in 1998-2000. These projects were in San Mateo, California; El Paso Co., Colorado; Baltimore, Maryland; Boston, Massachusetts, Belknap, Hillsborough and Merrimack Counties, New Hampshire; Tacoma, Washington; and Racine, Wisconsin. Principal findings in a preliminary 2002 report by Policy Studies, Inc. and Center for Policy Research are as follows:

- High increases in earnings were reported in most sites.
- Increases in employment were reported in the sites.
- Many fathers report additional time with children.
- Fathers who previously reported no child support payments reported paying some child support.

INDIVIDUAL DEVELOPMENT ACCOUNTS

Mr. Regula: Please describe this program. Who is served? How do individuals become aware of this opportunity? How are funds managed and invested? How many people are currently taking part in this demonstration program?

Dr. Horn: Individual development accounts (IDAs) are asset-development programs established by the Assets for Independence Act of 1998. This program provides funding for competitively awarded grants to non-profit organizations, local, State and Tribal governments partnering with non-profit organizations, and community development financial institutions. Grantees enroll IDA participants who must be below 200 percent of the federal poverty level and have assets below \$10,000 excluding a home and primary vehicle. IDA participants and the program sponsor (grantee) open up a matched savings account. Participants deposit their savings on a monthly basis and these savings are matched anywhere from 1-to-1 to 8-to-1 depending on the program sponsor. The funds can only be used towards first-time homeownership, business development and post-secondary education and training.

Funds are raised by the IDA program sponsor and managed by FDIC-insured financial institutions. The legislation requires a reserve fund to be established at the financial institution participating in the IDA initiative in which match funds are retained. Participants' funds are maintained in parallel accounts. Funds cannot be withdrawn except for explicit emergencies such as the participant facing eviction. Other requests for withdrawals before asset attainment result in expulsion from the program, per the statute. Individuals do not have access to match funds in the case of emergencies and withdrawals other than for the purchase of the asset.

Approximately, 10,000 people participate in these IDA grants. The participants are all low and moderate income individuals and families. Individuals become aware of the program through outreach and marketing from IDA sponsors who are charged to recruit participants. Grantees report that word-of-mouth from individuals who have succeeded with IDAs has assisted in recruitment for programs.

When a program participant meets his or her savings goal and investment plan, and completes asset-development training, the savings and match funds can be withdrawn for asset purchase (homeownership, business development and education). These funds must go to a third party: a bank for homeownership, vendor for business development and/or educational institution.

OFFICE OF REFUGEE RESETTLEMENT

Mr. Regula: In the Homeland Security Act, the Unaccompanied Alien Children program at INS was transferred to the Office of Refugee Resettlement in ACF. What was the rationale for this transfer?

Dr. Horn: For more than twenty years, the Office of Refugee Resettlement (ORR) has provided funds and overall management for the care and support of refugee unaccompanied minors. Altogether, about 11,700 youths have participated in the refugee unaccompanied minor program, most of them under foster care and group home arrangements. Recognizing that these types of arrangements may more provide appropriate support for struggling youth, Congress transferred the Unaccompanied Alien Children (UAC) program to ORR.

Mr. Regula: Please describe how that program will operate now that it is in ACF.

Dr. Horn: The UAC program was transferred to ORR on March 1, 2003. Consistent with the provision of the Homeland Security Act and the Flores settlement agreement, ORR will provide care and placement for these children in the least restrictive setting possible. To this end, we are (1) scheduling site visits to review all existing facilities under contract to the former INS, (2) entering into cooperative agreements with the two agencies experienced in the refugee unaccompanied minor program to expand shelter and foster care capacity, and (3) developing training for all staff on the assessment of the children and the facilities.

ORR is currently working to finalize a Memorandum of Understanding with the Department of Homeland Security to specify various roles and responsibilities under this transfer.

Mr. Regula: Are there estimates of how many unaccompanied alien children arrive in the United States each year and are there any data on what percentage will be served by the program? If so, please provide that information.

Dr. Horn: According to INS data, approximately 100,000 unaccompanied alien children arrive in the U.S. each year. Of these, over 5,000 children annually will be referred to ORR for care and placement. At any given time, approximately 600 youth are in our care.

DUPLICATIVE PROGRAMS

Mr. Regula: Are there any recommendations in this request that would eliminate or reduce redundant programs? Please describe those programs and tell us the rationale for eliminating each program from ACF and if there are other government programs serving the same populations.

Dr. Horn: Our budget identifies several duplicate programs for which we are not requesting funding:

- The Early Learning Opportunities Act program purposes and intent are quite similar to Early Reading First and the Early Childhood Education Professional Development Grant currently funded through the Department of Education.
- The Rural Community Facilities program provides water and waste water management, sanitation and distribution services similar to those services provided by the Environmental Protection Agency's Rural Community Assistance Program and the Department of Agriculture's Rural Development Programs.
- The National Youth Sports program provides sport and academic skills instruction similar to services that could be provided through the Community Services Block Grant funds.
- The Community Food and Nutrition program provides grants for food and nutritional assistance similar to services provided by programs housed within the Department of Agriculture's Food and Nutrition Service.

HEAD START

Mrs. Northup: Many Head Start programs are not serious about academic programs embedded in the program. Yet there is mounting evidence that proficiency in reading and mathematics skills in first grade are influenced by proficiencies in skill areas such as recognition of letters, numbers and shapes at kindergarten entry. These early skills are directly related to subsequent academic achievement.

Public dialogue has centered on Head Start and its limited curriculum, which includes a goal of children learning only 10 letters and not including serious mathematics concepts. We have poorly trained, poorly paid teachers delivering curriculum to a very small population of preschool children. High quality preschool education delivered to more children is needed - a system that would be good enough for the well-off, but made available to everyone. How is the Administration for Children and Families working to correct inattention to these important academic concepts?

Dr. Horn: This Administration has focused renewed attention on the issue of early literacy given the President's personal interest in having every child enter school ready to learn.

Locally, Head Start programs are assessing children's progress in the areas mandated by Congress, including alphabet knowledge, phonemic awareness, numeracy, and book handling skills. We are also launching a new national reporting system in the fall of 2003 to systematically track children's progress in a number of these key areas.

Last summer, we launched Project STEP, the largest, most intensive professional development effort ever undertaken by the Head Start Bureau. This training was designed to assure that every Head Start teacher - nearly 50,000 - understands the specific research findings behind the push to improve children's early literacy skills and the types of experiences that should be part of the daily curriculum to assure that children achieve the desired skills and outcomes. Continuing support is being given to teachers through an extensive network of skilled, early literacy mentor-coaches.

We have revised our on-site monitoring system and our training and technical assistance system to be certain that critical, age-appropriate, academic skills are part of every Head Start program. Each on-site review includes specifically focused classroom observations, teacher interviews, parent conversations, examination of local child outcome data, and review of individual child records.

Finally, efforts are continuing to improve the education and qualifications of Head Start teachers. In response to a congressional mandate that at least 50 percent of Head Start teachers have a college degree in early childhood education or a related field by the end of fiscal year 2003, there has been an increase from 37 percent in 1999 to 51 percent in 2002.

Mrs. Northup: As educators become more aware of the importance of early childhood education, there has been a proliferation of programs that are meant to better prepare children for school. However well intentioned these programs are, there is little evidence that many of them make a long term difference on a child's success in school. What is ACF doing to identify what works and what does not work?

Dr. Horn: There are a number of strategies being used at this time. We fund a cluster of Head Start University partnerships so that researchers can form partnerships with local Head Start agencies in order to conduct scientific studies of particular types of school readiness interventions, in particular early literacy interventions such as the *Letter People*.

Our partnerships with the US Department of Education, Office of Elementary and Secondary Education, also informs our work in critical early literacy areas through joint meetings, work on standards for early learning (as described in *Good Start, Grow Smart*) and in joint publications and dissemination strategies such as *Teaching Our Youngest*.

Every two years we sponsor a Head Start national research conference, the most recent being held in June 2002. This allows us to focus on research we fund and research funded by others. We feature research that focuses on or is relevant to Head Start programs. We also widely disseminate what we learn through these conferences.

We also are learning whether or not some of our efforts and investments are paying off through the trend data from our program monitoring and through the longitudinal data created through the administration of FACES – Family and Child Experiences Survey. We are seeing some progress in assuring more positive outcomes for children, but we still have work to do in assuring that every Head Start child is ready for school.

In addition, the Head Start Impact Study is underway and is designed to provide a national analysis of the impact of Head Start on the development and school readiness of low-income children. In addition to the primary question of Head Start's overall effectiveness, it will examine what types of services work best for which groups of children.

Finally, we will implement the National Reporting System in the fall for all programs serving preschool children. Assessments will focus on key indicators of early literacy, language development and numeracy learning. This information will be used to expand the information base on local program quality and effectiveness in Federal monitoring reviews, design and target new training and technical assistance efforts to improve local program effectiveness, and provide additional information supporting children's successful transition to school.

Mrs. Northup: Is the ACF working with IER at the Department of Education to establish guidelines for those who make these decisions?

Dr. Horn: The Institute of Education Sciences (IES) is still in its formation stage. We expect to work with the various arms of the IES as we continue to improve and strengthen Head Start programs in the academic areas of school readiness, especially in our early literacy and early childhood assessment efforts. We look forward to the leadership of Dr. Russ Whitehurst in his role as the first Director of the Institute, and we anticipate learning from the work of the Institute in building evidenced-based educational resources. We also are looking forward to the work of recently announced What Works Clearinghouse (WWC) within the Institute in order to inform the decision-makers in local Head Start programs.

We worked for many years with the former Office of Educational Research and Improvement (OERI), and on some occasions with the OERI Educational Labs in areas of shared interest, such as children's transitions from preschool to kindergarten. We were able to capture "best practices" and widely disseminate a community-wide guide to assessing transition practices.

WELFARE REFORM

Mrs. Northup: Since the passage of welfare reform in 1996, the number of individuals receiving cash assistance has been reduced by 56 percent. Even in a recession, national welfare caseloads did not rise significantly, instead, they stabilized. Since the law's passage in 1996, more single mothers are employed than ever before and child poverty rates are at their lowest level since 1978.

The purpose of TANF is to increase state flexibility in operating a program that helps needy families care for children at home; increase the independence of individuals by promoting job preparation, work and marriage; reduce out-of-wedlock pregnancies; and encourage the formation and maintenance of two-parent families.

The welfare reform bill passed in the House this session and again awaiting action in the Senate includes historically high levels of support for child care (currently at \$4.8 billion per year) through the Child Care and Development Block Grant (CCDBG), while adding \$2 billion in additional funds for child care in the coming five years. States can also transfer up to 50% of their TANF funds to the CCDBG. I am interested in the benefits that welfare recipients would qualify for under the 40-work-week requirement. Does the higher work requirement increase the number of working poor who would have work based benefits such as vacation pay, sick days, and health insurance?

Dr. Horn: Under our proposal and the House-passed HR-4, the work requirement is increased so parents become accustomed to a full work week of activities. To be counted for the required participation rate, clients must engage in monitored, constructive activities for a simulated full-time work week. At least twenty-

four of these hours per week must be in direct work activities of: unsubsidized employment, subsidized private sector employment, subsidized public sector employment, on-the-job training, supervised work experience, or supervised community service and up to 16 hours of other constructive activities. Employees in the first four activities would be entitled to any work based benefits that employers provide, including vacation pay, sick days, and health insurance. In addition, most clients will be eligible for the Earned Income Tax Credit to supplement their wages. As you know, the Administration's proposal also provides Transitional Medicaid or health coverage for a year for individuals who do not receive employer based health insurance.

LIHEAP

Mrs. Northup: Block grant funds available under TANF increase the flexibility of states in operating a welfare program that meets the greatest needs of local communities from year to year. Funds allocated to LIHEAP, on the other hand, lock money into energy and energy-only spending - even in years when it isn't a pressing concern for states.

The alternative system to provide heating assistance would include funding for energy emergencies in block grants associated with social services, TANF and other Children and Families Services programs. These block grants replaced welfare and are totally flexible, region by region and year by year. The welfare reform bill specifically allowed these funds to pay energy assistance. Some states have huge heating costs because they are in the north and the cost of power in their states is higher. Other states have other needs, waves of new immigrants, for example. Also, some years the weather is moderate, some years it is extreme. Would including LIHEAP dollars in the TANF block grants provide more flexibility to states in services to the poor?

Dr. Horn: Beginning in Fiscal Year 1994, the authorizing statute for LIHEAP does not permit the transfer of LIHEAP funds to other block grants. However, the Temporary Assistance for Needy Families (TANF) program includes flexibility that allows states to use TANF funds to assist low income families in meeting home energy needs. The TANF statute provides that states may use their TANF funds "in any manner reasonably calculated to accomplish" TANF purposes "including providing low income households with assistance in meeting home heating and cooling costs."

Mrs. Northup: Would there be beneficiaries of LIHEAP programs that would not be served under TANF programs? Can you propose a way to bridge this gap?

Dr. Horn: A low-income household that receives LIHEAP benefits is not excluded from receiving TANF, and vice versa. The LIHEAP statute at section 2605(b)(2) provides for categorical eligibility, which means states may determine households automatically eligible for LIHEAP assistance if those households receive benefits from TANF, SSI, Food Stamps and some Veterans programs.

Mrs. Northup: Local power companies often work to address cost issues for low-income consumers. Could heating bills being covered some other way that does not absorb funds for other vital service programs?

Dr. Horn: States are demonstrating through the LIHEAP Leveraging Incentive Program their ability to maximize the federal dollars they receive. The leveraging program was created to encourage states to look for ways to add non-federal dollars or other resources to their LIHEAP programs. Most states actively work with utilities and fuel vendors to obtain discounts, fuel funds and other forms of assistance for LIHEAP and low income households.

States also purchase heating fuels for low-income households using private or public non-federal funds, obtain utility forgiveness of significant home energy bill arrearages for needy families, solicit and distribute donated fuels, and solicit and distribute donated and unpaid volunteer services to install, replace and repair home energy apparatuses.

Mrs. Northup: Is there a way that we could include funding for such energy emergencies within grants to the states to increase their flexibility to address the greatest needs that face their populations from year to year?

Dr. Horn: The LIHEAP program, as a block grant, provides great flexibility to the states to design their energy assistance programs in the way that they believe best serves the needs of their low income populations. A state may set aside as much of their funds as necessary from their LIHEAP allocation to be used for crisis assistance, including establishing a crisis component that provides benefits specifically for winter and/or summer emergencies. Also, at any time, a state can amend its fiscal year plan submitted to HHS if the state later chooses to re-direct funds to other areas of its LIHEAP program. This would include re-directing funds to establish crisis benefits in the event of an unforeseen emergency, such as a severe cold snap or a prolonged heat wave.

TANF CHARITABLE CHOICE

Mrs. Northup: Last year, the President announced proposed rules that would clarify the rights and requirements of States and faith-based or community organizations when using TANF or maintenance-of-effort (MOE) funds. The proposed rules ensure that faith organizations are treated equally with other organizations in competing for funds under TANF.

On the same day, regulations authorizing states to use faith-based groups, as well as charitable, private and neighborhood-based organizations, in programs supported by the Community Services Block Grant (CSBG) program were also released.

I note that the public comment period on these proposed regulations was February 18. Can you give me any feedback on the public input your agency received on these issues?

Dr. Horn: The Administration for Children and Families (ACF) received comments on these proposed rules from a number of organizations and individuals. We will provide a complete analysis of the comments in the preamble to the final rule. In general, comments ranged from broad to very specific recommendations for changes in the regulations. Some comments were very supportive of the regulatory provisions, while others opposed both the regulatory and the "charitable choice" statutory framework.

Mrs. Northup: Numerous faith-based programs have shown considerable success in their ability to meet the needs of the people in my district. From counseling the troubled to feeding the hungry and caring for the disabled, I have been impressed with their commitment and capacity to serve. These innovative and practical organizations operate on less than significant amounts of money with great success, so I would be happy to see greater resources allocated to such programs. How can we encourage more government to organization cooperation with the most effective programs in any given locality?

Dr. Horn: The Compassion Capital Fund (CCF) program supports intermediary organizations to assist faith-based and community organizations in readying for the partnership of federal-local organizations in providing needed services to the community. Intermediaries assist these small groups in their efforts to improve effectiveness and organizational management, access funds from diverse sources and manage those funds, develop and train staff, expand the types and reach of social services programs in their communities and develop promising collaboration among organizations dedicated to social service delivery. Intermediary organizations serve as a bridge between the federal government and small faith-based and community organizations that the CCF program is designed to assist.

Mrs. Northup: Does the Administration of Children and Families have a method in place to evaluate the effectiveness and results-based outcomes of these charitable, private and neighborhood-based programs?

Dr. Horn: Although we are in the early stages of implementation for the Compassion Capital Fund, we already have begun the necessary work toward performance measurement. This effort is a comprehensive strategy to develop measures that will not only assess the outcomes of the program's efforts, but also will highlight what strategies work in utilizing this group of organizations to provide services. Information culled from the assessment of grantees will be used to document programs operated under the Compassion Capital Fund so that practices are measured, and successes emulated or expanded.

POSITIVE YOUTH DEVELOPMENT

Mr. Weldon: I understand that the Family and Youth Services Bureau has sponsored a Youth Summit, here in DC, that focused on positive youth development. What particular programs in ACF are promoting positive youth development? What are some examples? How does this work to reduce the social pathologies that affect youth, improve child welfare, and reduce child poverty?

Dr. Horn: The positive youth development approach within ACF is predicated on the understanding that all young people need support, guidance, and opportunities during adolescence, a time of rapid growth and change. With this support, they can develop self-assurance in the four areas that are key to creating a happy healthy and successful life: (a sense of competence; a sense of usefulness; a sense of belonging; and a sense of empowerment)

The Family and Youth Services Bureau (FYSB) within ACF is responsible for administering the Nation's Runaway and Homeless Youth (RHY) Program. All FYSB grantees are required to establish a positive youth development plan. FYSB also funds 13 Youth Development State Collaboration Projects through its Research and Demonstration authority. These grants were established in order to support innovative youth development strategies at the State level.

The positive youth development approach employed by our grantees has demonstrated success in reducing risk factors and increasing assets. Organizations such as the Search Institute and some States, like Vermont, have been able to connect healthy behaviors with the assets associated with positive youth development. Their studies and surveys have identified and tracked protective and constructive assets in young peoples' lives. Findings show how possession of such assets is positively associated with healthy behaviors such as abstinence, sobriety, participation in aerobic exercise, etc. Favorable outcomes and healthy habits trend steadily upward in direct proportion to increasing numbers of assets that may be present in young persons' lives.

In addition to efforts under FYSB, other ACF program activities address positive youth development with their mission. For example, the Head Start Bureau funds over 40 demonstration projects serving youth within Head Start families. In one program, Head Start staff, Education Coordinators and Training Specialists are providing leadership and job training for 34 youth 12 – 18 years old who were previously Head Start children, older siblings of current Head Start children, or are active in an existing youth empowerment program.

CHILD POVERTY REDUCTION

Mr. Weldon: You have said in the past that the best child anti-poverty programs are stable and intact families. Your administration is promoting marriage, fatherhood, adoption, and programs that seek to reduce out-of-wedlock births as a part of TANF.

Indeed, child poverty is at an all time low, and some of the most dramatic gains have been among minority children. How have the programs that I mentioned worked to contribute to the reduction of child poverty?

Dr. Horn: One of the key predictors of poverty is single parenthood, so the Administration's proposals are designed to address this root cause through a comprehensive, reinforcing strategy. What welfare reform has taught us over the past five years is the crucial importance of putting work and family responsibility at the center of public assistance. The goal of using welfare reform to support marriage is not a new one; indeed, strengthening marriages and reducing out-of-wedlock child-bearing are two goals clearly spelled out in the 1996 welfare reform law. To reduce the incidence of single parenthood, we must increase the attention given to the creation and maintenance of healthy families and, at the same time, improve work opportunities and supports for parents. Accomplishing that means we will have to do several things.

- We need to promote and foster the critical importance of marriage in society, both for the tremendous lifelong benefits to children, as well as to the partners. Our TANF reauthorization proposes a \$100 million annual fund to conduct research and demonstration projects and provide technical assistance primarily focusing on family formation and healthy marriage activities and the creation of a \$100 million matching grant program for States to develop innovative healthy marriage programs.
- We must continue efforts to support abstinence until marriage and the recent progress on reducing teen pregnancies and out-of-wedlock births. The President's plan reauthorizes abstinence education programs and maintains funding at \$50 million a year. It increases funding for community-based abstinence education, and it continues funding for Adolescent Family Life programs.
- To ensure that all parents have opportunities for independence, the Administration's proposal requires State welfare agencies to engage all families in work and other activities leading to self-sufficiency. It requires all families to participate in a simulated full-time work week with at least 24 hours per week in direct work activities and up to an additional 16 hours in other constructive activities. The plan also gives work credit to families engaged in short-term substance abuse treatment, rehabilitation and work-related training.
- When we are not successful in forming healthy marriages, we need to ensure that both parents support their children financially through child support. The 1996 welfare reform law has led to significant increases in child support payments from non-custodial fathers, and we will continue these efforts. But, there is less evidence that these fathers are becoming more involved in their children's lives. We need more programs to help fathers become an involved and committed presence in their children's lives, which is why the Administration supports a wide variety of fatherhood programs and is

proposing to expand funding for Access and Visitation Grants from \$10 million to \$20 million by FY 2007. We also must find new and innovative ways to recruit and then retain fathers in these programs.

- And in the cases where these efforts to promote healthy families and involved parents with work and increased income fails, we absolutely must protect the safety and well-being of each and every child through enhanced child protection, family preservation and adoption.

STRENGTHENING THE PARENT-CHILD BOND

Mr. Weldon: Research shows that many of the problems that contribute to children running away from home, and youth involvement in risk behaviors that can compromise their health, education and futures can be prevented by strong parent-child connections and strong connections between children and their schools. Many government programs, however, instead of helping parents seek to replace parents. How has your administration sought to promote and strengthen parent-child connectedness?

Dr. Horn: Recognizing the concerns you raise, at the center of the Administration's plan are efforts to promote and improve child well-being. Our TANF reauthorization proposal establishes an overarching purpose of welfare reform to improve the well-being of children. It clarifies encouragement of healthy marriages as a goal of the TANF program and provides targeted resources to support that goal and the development of innovative approaches. Nearly all TANF programs provide time management and parenting training to improve the abilities and skills of mothers to help their children grow and nourish. We also have supported fatherhood demonstrations to actively engage fathers in the lives of their children and seek expanded resources directed toward these efforts. The specific proposals are noted in your earlier question.

Our work on positive youth development also aims to strengthen parent-child bonds. The program is predicated on the understanding that all young people need support, guidance and opportunities during adolescence.

Finally, we are making notable progress in strengthening parent child bonds through adoption. The number of children adopted from the foster care system grew from 31,000 in FY 1997 to 50,000 in FY 2001. We expect the final numbers for FY 2002 will exceed last year's impressive results.

CHILD SUPPORT ENFORCEMENT

Mr. Weldon: For many years states have been working to implement federally required and subsidized computer systems intended to track child support orders and payments from non-custodial parents for the support of their children. Unfortunately, these computer systems have not met the needs of states or the requirements of the federal government and resulted in millions of dollars spent on technology instead of the needs of children. What progress has ACF made in rectifying this situation?

Dr. Horn: The technology supported by the Family Support Act of 1988 (FSA), and later the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), has been increasingly effective in meeting the needs of children. In addition to tracking and monitoring cases, these automated systems support all aspects of child support enforcement.

Today, 52 States and territories have systems that meet the requirements of FSA; 50 have implemented the automation requirements of PRWORA, with two additional States indicating they will be compliant by this coming September. Expenditures on developing child support systems represent 18 percent of all expenditures for State child support programs, and the percentage is expected to decline now that most statewide systems are operational. The vast majority of States have indicated in their cost-benefit analyses that their returns have exceeded their investments for their statewide system development efforts several years earlier than originally projected.

There have been dramatic increases in the effectiveness of the child support enforcement program due to improvements in technology since 1997.

- Collections are up 42 percent, from \$13.4 billion to \$19 billion in fiscal year 2001. One of the largest increases in the amount of collections during this period is due to better wage withholding attributable to improved automatic matching of newly hired employees and child support caseloads. This matching results in automatic new wage withholding orders once an employer is identified.
- The percentage of the total caseload with collections is up 100 percent, from 22 percent to 44 percent.
- The percentage of total cases with orders that had collections increased 79 percent, from 38 percent to 66 percent.
- The impact of automation is apparent in all aspects of child support enforcement -- location, paternity, and order establishment as well as collections of current and past-due child support. Nearly 1.6 million paternities were established, up 21 percent from 1997. Sixty-six percent of cases have child support orders established, up 15 percent since 1997.

ADOPTIONS FROM FOSTER CARE

Mr. Weldon: What is the status of adoptions from foster care, particularly with respect to older minority children? What is ACF doing to eliminate the disparity in adoptions from foster care between white younger children and minority older children?

Dr. Horn: Between age and minority status, age is by far the greatest barrier to adoption. Analysis of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) shows that once a child reaches age nine years old, regardless of racial or ethnic background, the probability that the child will continue to wait in foster care exceeds the probability that the child will be adopted. In FY 2001, the average age for adoption of minority versus Caucasian children was about the same, between the age of 6 and 7. Further, the number of older children in the system is growing. The Administration proposes addressing this issue through revisions to the Adoption Incentive program. We propose to award incentives using two separate baselines, one for all adoptions and one for older youth. This proposal will continue to reward increased adoptions for all children over the baseline at a rate of \$4,000 and an additional \$6,000 for older children over a separate baseline. This new proposal will focus States' attention on the growing permanency needs of all older foster youth, who traditionally have been more difficult to place.

ADOPTION AWARENESS

Mr. Weldon: The Infant Adoption Awareness Program has begun implementation and outreach in the Southeast, which includes Florida. While this program is still getting started, I am particularly interested in reviewing its initial findings and data when available.

Dr. Horn: Although the data is very preliminary, the work of the Infant Adoption Awareness Training Program grantees is proceeding at a pace faster than anticipated and is exceeding its goals. There are four grants - one is national in scope; two regional efforts - Southeast and Upper Midwest; and one that is state specific - Arizona.

The grantees have conducted approximately 110 training sessions that included about 2,200 individuals who provide a wide range of services to pregnant women. (This does not include Training the Trainers workshops.)

The training modules developed by all four grantees are designed for one to four days of instruction, depending on the time availability of the staff to be trained. During the first few months of training, the modules were refined to address the informational and time needs of those to be trained.

All grantees have developed specific curriculums, a web-site that provides referral in the respective communities, a PowerPoint presentation, and videos as a learning tool and newsletters. One grantee, Spaulding for Children, has developed several videos. One is specifically targeted to teens, one to adults, and a third is in Spanish.

The trainees have consistently assigned high satisfaction scores (90 percent or above) for the training. Trainees also show a marked improvement in their understanding of adoption issues from their pre- to post test.

COMMUNITY SERVICES BLOCK GRANT PROGRAM

Mr. Obey: According to your budget, the Administration is proposing to cut the CSBG program by 23%, due in part to a "lack of strong performance data." However, in the performance section of the budget, the statement is made that, in terms of meeting the two key national goals, local community action agencies exceeded the first goal of increasing volunteer contributions by more than 9%, from 27.7 million hours in 2000 to 30.3 million hours in 2001. The stated goal was a 2% increase in volunteer contributions. On the second goal of "leveraging" federal funds, the budget states that the levels of non-Federal funds have consistently increased since 1997. This appears to contradict the stated rationale for the proposed budget cut. Please explain this to me. The Community Action Agencies tell me that they would be happy to develop additional performance data. What is the ACF's Office of Community Service doing to help the CAAs? Who is responsible for the so-called lack of performance data?

Dr. Horn: The Administration is working collaboratively with State CSBG authorities and local eligible entities to identify approximately 10 to 12 national performance indicators for the CSBG program. Most of the outcome measures being considered are those for which data are not being collected from a majority of States and eligible entities through "Results Oriented Management and Accountability," or ROMA. ROMA has been a bottom-up, mostly voluntary, process over the past nine years to install performance-based systems among States and local agencies receiving CSBG funding. By making these outcome measures mandatory, as part of the CSBG reauthorization, more consistent data can be collected and an analysis of effectiveness can be conducted for each grantee.

From its inception, ROMA has been premised on collaboration among the Federal, State and local entities that comprise the CSBG Community Services Network. The Department has utilized its training and technical assistance authority to underwrite the development of voluntary national goals to focus the work of agencies receiving CSBG funding, model tools for measuring family, community, and agency outcomes, and provide training of State and local program officials on how to utilize outcome-focused management principles to redesign and strengthen service delivery strategies, family and community outcomes.

Mr. Obey: Your budget proposes a cut of \$155 million for Community Services Block Grants, a cut of 24% below the \$650 million we provided for FY 2003. What is the potential impact on local Community Action Agencies as a result of the proposed cut?

Dr. Horn: The Temporary Assistance for Needy Families and the Social Services Block Grant Program can support a broad array of services, including many services provided by the Community Services Block Grant. States may use this flexibility to support similar services.

Mr. Obey: In the Conference Report on the FY 2003 Omnibus Appropriations Act, the Conferees requested that the Secretary of Health and Human Services provide a report on unexpended Community Services Block Grant funds. What is the status on that report?

Dr. Horn: The conferees requested that the Secretary of the Department provide to the Committee on Appropriations a report detailing the levels of unexpended balances of CSBG funds in each State for the period of fiscal year 1995 through fiscal year 2002. On March 11, the Office of Community Services requested the level of unexpended balances from the States. This report will be available for the Committee by the requested date of August 15.

COMPASSION CAPITAL FUND

Mr. Obey: The Administration has requested \$100 million for the Compassion Capital Fund, an increase of \$65.2 million, nearly tripling the program in one year. Could you please describe for me what those programs have accomplished that suggests that an increase of that magnitude is appropriate? Please provide the performance data supporting that increase. Have you awarded contracts obligating all the FY 2003 appropriated funds? Please provide list of grantees and the date of contract award.

Dr. Horn: Although we are in the early stages of implementation for the Compassion Capital Fund, we already have contracted with two research and development firms to begin the necessary work toward performance measurement. Those firms, Branch Associates and Dare Mighty Things, will assess best practices in faith-based organizations through several CCF demonstration project grantees within a sample of 8 to 10 intermediary organizations. This effort is a comprehensive strategy to develop measures that will not only assess the outcomes of the program's efforts, but will also highlight what strategies work. Using information culled from the assessment of grantees, Dare Mighty Things will develop and maintain the National Resource Center. The National Resource Center will document programs operated under the Compassion Capital Fund so that practices are measured, and successes emulated or expanded.

Last year the competition for the Demonstration Program included 367 applications and the competition for the research grants included 73 applications. The Office of Community Services and the HHS Center for Faith-Based and Community Initiatives field calls and inquiries daily for information about funding. In Fiscal Year 2002, the appropriation allowed us to fund 21 demonstration grants, four research grants, and two contracts for best practices and the National Resource Center. Only a limited number of new grantees can be funded this year, however. OCS will hold the next competition for new grantees this summer to award the FY 2003 grants.

Only a small number of the many faith-based and community organizations that wish to expand their existing capacity will be served by current CCF grantees. An expansion of the CCF program will allow more intermediary organizations to receive funding in turn allowing more faith-based and community organizations in all parts of the country to receive the capacity-building services and other support offered by CCF grantees.

Following is a list of grantees and contractors and the grant and contracts amounts for award of the FY 2002 grants. All grants and contracts were awarded September 30, 2002.

Compassion Capital Fund Demonstration Program

United Way of Massachusetts Bay	MA \$ 2,000,000
JVA Consulting, Inc.	CO \$ 1,008,547
Christian Community Health Fellowship	IL \$ 1,128,330
The National Center for Faith Based Initiative	FL \$ 700,000
Montana Office of Rural Health	MT \$ 614,555
Associated Black Charities, Inc.	MD \$ 1,500,000
Clemson University	SC \$ 1,033,341
Southeast Asia Resource Action Center	DC \$ 682,240
Community Technology Centers' Network (CTCNET)	MA \$ 1,499,770
Emory University	GA \$ 1,499,999
Operation Blessing International	VA \$ 500,000
Mennonite Economic Development Associates	PA \$ 1,000,000
Nueva Esperanza, Inc.	PA \$ 2,466,406
University of Nebraska	NE \$ 1,160,742
CJH Educational Grant Services, Inc.	NC \$ 1,506,987
Institute for Youth Development	VA \$ 2,500,000
Catholic Charities of Central New Mexico	NM \$ 1,000,000
Northside Ministerial Alliance	MI \$ 1,000,000
Volunteers of America, Inc.	VA \$ 699,159
University of Hawaii	HI \$ 600,000
S.V.D.P. Management, Inc.	CA \$ 673,041
TOTAL	\$24,773,117

Compassion Capital Fund Research Projects

Caliber Associates	\$236,633
Florida International University	\$210,622
University of Maryland, College Park	\$218,098
University of Pennsylvania	\$193,456

Contract Examining Services and Best Practices of Intermediary Organizations and the Faith- and Community-Based Organizations they Serve
 Contractor: Branch Associates/Abt Associates (Subcontractor)
 Contractor Amount: \$1.35 million

Contract to establish a National Resource Center: provide technical assistance to the CCF grantees, to facilitate collaboration among CCF intermediates, and disseminate information to the public
 Contractor: Dare Mighty Things
 Contractor Amount: approximately \$2 million

MENTORING CHILDREN OF PRISONERS

Mr. Obey: I would also be interested in progress on another component of the Administration's Faith-Based and Community Organizations initiative, the Mentoring of Children of Prisoners for which this Subcommittee provided \$9.9 million in FY 2003. The Administration has requested \$50.0 million for this program in FY 2004. This is a well-intentioned, but new program; FY 2003 is the first year of funding. What is the basis on which you are requesting an increase of over 400%? Please provide the performance data on this program. What is the status of this initiative? Please provide a listing of grantees and the date of contract award.

Dr. Horn: The basis for the request centers around the fact that approximately 2.1 percent of all children in the United States has a parent in Federal or State Prison. Research has found that children of incarcerated parents are seven times more likely to become involved in the juvenile justice system. These children are exposed to stress, trauma, separation and stigmatization resulting from the arrest of a parent. Compounded by existing poverty, violence, substance abuse, high-crime environments, child abuse and neglect, these young people are seriously at-risk for failure in school, confrontations with the law and lack the skills to form successful relationships.

The President is committed to supporting the training and recruitment of a cadre of mentors to serve as positive role models for more than 6,000 children of incarcerated persons. The \$40 million increase in the Mentoring Children of Prisoners Program will allow an additional 26,000 children and families to be served in the coming years.

The program announcement (RFP) soliciting applications for grant funding for the Mentoring Children of Prisoners Program should be published in the *Federal Register* in early summer. The authorizing legislation for the program includes a requirement that the grantee to submit as a part of their program design, methods to evaluate outcomes for participating children. The quality of their evaluation design will be assessed within the grant competition. The grantee must further agree to participate in the ongoing and final evaluation conducted by the Secretary that will be submitted to Congress. Grantees will be required to submit semi-annual and annual reports, which will contain data that will be used in the evaluation.

REFUGEE PROGRAM

Mr. Obey: With regard to the Refugee and Entrant Assistance program, there have been reports in the media to the effect that the number of refugees in 2002 were less than half of the authorized of 70,000 refugees. Has the Department of State provided you with an estimate of the number of refugees for last year? What is the impact of this decline in the number of refugees on the funding level in 2004?

Dr. Horn: In FY 2002, the Office of Refugee Resettlement (ORR) recorded the following arrivals: 27,106 refugees, as well as 5,658 Cuban/Haitian entrants, 11,064 Havana parolees, 34,308 asylees, and 99 victims of a severe form of trafficking – for a total of 78,235 arrivals of persons eligible for the assistance and benefits of the refugee program. The reduced number of refugee arrivals should reduce Refugee Cash and Medical Assistance expenditures during the first half of FY 2003. The expenditures for FY 2003 Cash/Medical/Administrative costs are difficult to estimate, because the lower arrival numbers in FY 2002 are offset somewhat by the more difficult employment environment during the past year and the uncertainty regarding the flow of refugees into this country during FY 2003. For FY 2004, there has been a reduction in our request for Refugee Cash and Medical Assistance of over \$19 million, taking into account the reduction in arrivals.

HEAD START

Mr. Obey: The Administration has requested an increase of \$148 million for the Head Start program. This is an increase of 2.2%, which is roughly inflation. However, you have said in both the budget justification and in your statement, that this would permit you to increase Head Start enrollment by 10,500. Please explain how this is possible.

Dr. Horn: The President's FY 2004 budget request proposes to reallocate approximately \$68 million of training and technical assistance funds which would be used to increase enrollment by approximately 10,500 children in those parts of the country with the greatest unmet need for Head Start services. There has been a rapid growth in the amount of training and technical assistance funds in recent years and we believe a portion of these funds could be better used to serve more children. Our ability to reallocate the use of technical assistance funds depends on the enactment of the Administration's proposed Head Start reauthorization.

Mr. Obey: You have announced plans to conduct a national assessment of four-year-old children enrolled in Head Start. What is the cost of this assessment? What is the source of the funding? Who is developing the assessment tool for the Department? What was the process that the Department followed in selecting this particular entity to develop the assessment tool? Was this a full and open competition? Please provide a chronology of the relevant dates for this competition.

Dr. Horn: In addition to Federal staff time, the main cost of developing the national assessment system has been a contract to Westat, Inc. which included a subcontract with Xtria, Inc. The contract was funded for \$1,452,354 in fiscal year

2002 and \$767,249 planned for fiscal year 2003. We expect that some additional contractual assistance will be needed to carry this work into the future, but we do not have an estimate of these costs at this time.

We also anticipate that there will be costs later this year for training Head Start staff who conduct the child assessments. Although plans are still being developed, we estimate the needed training for some 37,000 local Head Start and local staff will also need to devote time to conducting the actual assessments of more than 500,000 children twice a year. We estimate total costs at \$22 million.

Head Start training and technical assistance funds are being used for contractual costs. We anticipate using current Head Start program funds to provide supplements to local Head Start programs to help support the cost of training and conducting the assessments. All of these funds are available within current appropriation levels.

The Department is currently working to develop the assessment tool. Over the past year, the Head Start Bureau convened a series of focus groups, workshops, and discussion sessions with leaders from local Head Start programs, early childhood researchers, and experts on assessment strategies for young children. These activities broadened our awareness of the strengths and limitations of currently available assessment tools (including those most commonly used in Head Start programs for ongoing assessment of children), research on key components and indicators of school readiness, and issues and concerns around development of the national reporting system.

A Technical Work Group of 16 experts, co-chaired by Dr. Craig Ramey, Georgetown University, and Dr. Clancy Blair, Pennsylvania State University was created. The Technical Work Group is providing ongoing advice and support to the Bureau in the development and implementation of the assessment system. In addition to these opportunities for consultation and input, the Bureau convened an invitational conference for Head Start Directors in Washington, D.C. on January 16, 2003 to provide a comprehensive briefing on the status of planning and development of the system.

In obtaining contractual support, the Department's normal competitive procurement procedures were followed. Based on the limited scope and duration of the project, a Task Order Contract process was utilized via the Department's Program Support Center, Office of the Assistant Secretary for Administration and Management. Four contractors with relevant experience in the area of early childhood assessment and evaluation were invited to respond to a Statement of Work under Task Order Competition # 02Y002210 on August 12, 2002. Proposals were due on September 4, 2002. Following the proposal review process, Contract # 282-98-0015, T.O. #43 was awarded to Westat, Inc. on September 30, 2002.

Mr. Obey: Please provide similar information regarding the contracting process for the new training program for Head Start teachers which you described in your opening statement.

Dr. Horn: In the summer of 2002 we provided four days of training, in 20 locations throughout the country, to over 3,000 Head Start staff on how to help children develop skills in early literacy. These staff then went back to their programs and provided this training to Head Start's 50,000 teachers. The training provided to the 3,000 Head Start staff was through the Head Start Bureau's Training and Technical Assistance Network. This year we also have provided intensive training to a network of 300 mentor coaches who, upon request, visit Head Start programs to help them develop better approaches to working with children in the area of early literacy. The Head Start Bureau's Training and Technical Assistance Network also provided this training.

HEAD START FUNDING

Mrs. Lowey: I also think the Administration needs to realize that our kids need balanced meals before, during, and after school. They need warm, comfortable, and clean clothing in order to learn. And they need safe, structured, and encouraging environments in which to study. Head Start teaches parents these lessons, while also providing our kids with the right tools and motivation to learn.

The president says he wants to give the states more flexibility to administer Head Start, and wants to retool the program to ensure greater success amongst program participants. If this was really true, wouldn't the Administration have requested additional funding for the program? Head Start's budget will barely keep up with inflation, yet the program is only serving six of 10 eligible poverty-line children.

Dr. Horn: The President's request proposes, at a time of tight fiscal constraints, to increase Head Start funding by almost \$150 million. Furthermore, recognizing that there are still unserved Head Start eligible children, the President's budget proposes to reallocate some of Head Start's training and technical assistance funds to increase enrollment by 10,500 children in those parts of the country with the greatest unmet need for Head Start services. We believe that allowing interested states to manage Head Start and better coordinate it with other child development programs that they already administer will, in many cases, result in expanded services that reach more eligible children and families.

LIHEAP FUNDING

Mrs. Lowey: While I am pleased that the President proposed adding \$300 million in emergency funding to the Low Income Home Energy Assistance Program (LIHEAP), I was disappointed to see a cut of \$88 million in regular funding. According to the Energy Information Administration, heating oil prices are up by 50 percent, natural gas prices are up by 79 percent, and weather conditions were 28 percent colder than last year. These factors, combined with the high rates of unemployment, suggest that the need for assistance will be increasing, not decreasing. Shouldn't the budget reflect the growing need for assistance by providing more for LIHEAP? Do you think the Administration's budget is adequate?

In addition, preliminary data suggests that there will be a significant increase in the number of households receiving shut-off notices when current state shut-off moratoriums begin expiring at the end of this month. How can we expect families, who are struggling to make ends meet through this economic downturn, to pay off the energy bills they have accrued? How are you planning to address the problem? Are you going to request a supplemental appropriation for LIHEAP?

Dr. Horn: In the President's budget proposal for LIHEAP for FY 2004, \$1.7 billion in regular block grant funds, and \$300 million in Emergency Contingency Funds is requested. The total amount of funds requested for LIHEAP (\$2 billion) in FY 2004 is over \$200 million greater than Congress appropriated in FY 2003.

The final FY 2003 appropriation did not include the \$300 million in Contingency Funding. In fact, the additional funding in the regular block grant program came from the conversion of emergency funds carried over from the FY 2001 supplemental appropriation.

President Bush also released an additional \$200 million in emergency energy funds for States, Territories and Tribes due to continuing increases in home heating fuel prices this past winter. Further, the Administration has worked with States to waive requirements for withholding amounts for quarterly grant distribution to ensure that States with greater winter needs are able to serve their populations with the funds available. With this additional funding and flexibility, the Administration has worked to ensure that States have been able to assist or provide additional benefits to low income households.

There are other programs in HHS with flexibility to help States alleviate the impact of home energy bills on low-income households. States can transfer up to 10 percent of their Social Services Block Grant (SSBG) funds to LIHEAP. As an alternative, they can use their flexibility under SSBG to provide emergency energy assistance through that program. States may also use Temporary Assistance for Needy Families (TANF) funds to meet the ongoing or emergency energy needs of low-income families. We expect states to utilize this flexibility to address additional energy needs.

LIHEAP HOT WEATHER ASSISTANCE

Ms. Roybal-Allard: Based on the severe winter weather, I would be interested to know where we stand with regard to LIHEAP funds. As you know, California is far more likely to use LIHEAP for energy assistance related to hot weather. Is there any surplus remaining in the fund for states like California to cope with hot weather, and if not, what are the Department's plans to cope with emergency needs that are likely to crop up during the rest of the fiscal year?

Dr. Horn: The LIHEAP program provides much flexibility to the States to design their energy assistance programs in the way that they believe best serves the needs of their low income populations. A State may set aside as much of their funds as necessary from their LIHEAP allocation to be used for heating or cooling, and for crisis assistance, including establishing a crisis component that provides benefits specifically for summer emergencies. A State may use both its regular block grant funds and emergency contingency funds to address such crises.

In addition, States can amend their fiscal year LIHEAP plan submitted to HHS if the State later chooses to re-direct funds to other areas of its LIHEAP program. This would include re-directing funds to establish crisis benefits in the event of an unforeseen emergency, such as a prolonged heat wave.

California does not currently operate a LIHEAP cooling component, and instead operates a year round program that provides both heating and cooling payments to eligible households.

While Congress did not appropriate LIHEAP contingency funds for FY 2003, there are other programs in HHS with flexibility to help States alleviate the impact of home energy bills on low-income households. States can transfer up to 10 percent of their Social Services Block Grant (SSBG) funds to LIHEAP. As an alternative, they can use their flexibility under SSBG to provide emergency energy assistance through that program. States may also use Temporary Assistance for Needy Families (TANF) funds to meet the ongoing or emergency energy needs of low-income families. We expect States to utilize this flexibility to address additional energy needs.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR

2004

**Administration for
Children and Families**

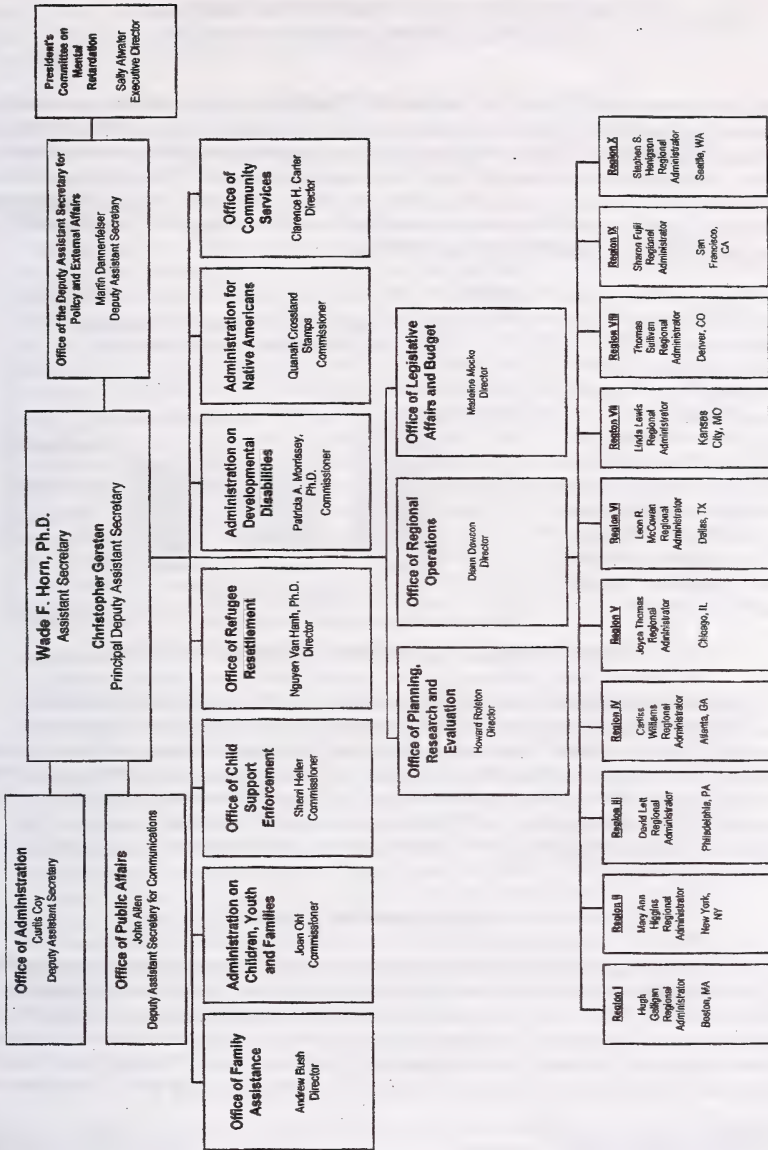
*Justification of
Estimates for
Appropriations Committees*

JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES
ADMINISTRATION FOR CHILDREN AND FAMILIES

TABLE OF CONTENTS

	<u>Page</u>
ACF ORGANIZATION CHART	
OVERVIEW OF THE FY 2004 BUDGET REQUEST.....	A-1
ALL-PURPOSE TABLE.....	A-3
ENTITLEMENT PROGRAMS:	
▪ Payments to States for Child Support Enforcement and Family Support Programs.....	B-1
▪ Payments to States for Foster Care and Adoption Assistance.....	C-1
▪ Social Services Block Grant.....	D-1
▪ Promoting Safe and Stable Families.....	E-1
DISCRETIONARY PROGRAMS:	
▪ Low Income Home Energy Assistance Program.....	F-1
▪ Child Care and Development Block Grant.....	G-1
▪ Children and Families Services Programs.....	H-1
▪ Refugee and Entrant Assistance.....	I-1
PRE-APPROPRIATED PROGRAMS:	
▪ Temporary Assistance for Needy Families.....	J-1
▪ Child Care Entitlement to States.....	K-1
▪ Children's Research and Technical Assistance.....	L-1
FY 2004 PERFORMANCE PLAN AND FY 2002 PERFORMANCE REPORT.....	M-1

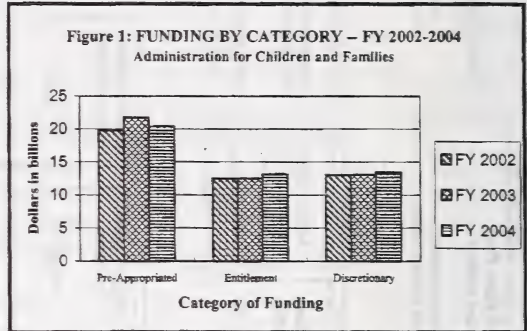
Administration for Children and Families



OVERVIEW OF THE FY 2004 BUDGET REQUEST ADMINISTRATION FOR CHILDREN AND FAMILIES

The Administration for Children and Families (ACF) administers programs which promote the economic and social well-being of children, youth, and families, focusing particular attention on vulnerable populations including preschool age children, adolescents, families and children in crisis, the developmentally disabled, Native Americans, and refugees. These programs, which are carried out by State, territorial, county, city, and tribal governments – as well as by private, nonprofit, community and faith-based organizations – have been designed to promote stability, economic security, responsibility and self-sufficiency.

ACF budgetary resources appropriated by the Congress are in three major categories – pre-appropriated, entitlement, and discretionary programs – as shown in Figure 1. The FY 2004 President's Budget request for activities administered by ACF is \$47.0 billion – \$405 million below the FY 2003 President's Budget level.



PREAPPROPRIATED AND ENTITLEMENT FUNDING

Approximately two-thirds of the ACF budget request in FY 2004 is for preappropriated or entitlement programs -- that is, programs whose funding is determined outside the scope of annual appropriations bills. These programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, Foster Care and Adoption Assistance, Promoting Safe and Stable Families, the Social Services Block Grant, Children's Research and Technical Assistance, and the Child Care Entitlement. In FY 2004, approximately \$33.5 billion is requested for mandatory spending programs, a \$773 million decrease (-2 per cent) below the FY 2003 President's Budget.

DISCRETIONARY FUNDING

The discretionary portion of this budget request is composed of funding for such programs as the Low Income Home Energy Assistance Program (LIHEAP), the Child Care and Development Block Grant (CCDBG), Head Start, and the Community Services Block Grant. In addition, this request includes funding for Presidential priority programs, including the Compassion Capital Fund, Mentoring Children of Prisoners, Maternity Group Homes, and Promotion and Support of Responsible Fatherhood and Healthy Marriage. Discretionary spending in ACF is proposed to

increase to \$13.4 billion in FY 2004 -- \$369 million (+2.8 per cent) above the FY 2003 President's Budget. The ACF budget request would support 1,472 full-time equivalent (FTE) positions in FY 2004 -- 40 FTE below the FY 2003 level.

HIGHLIGHTS OF THE FY 2004 BUDGET REQUEST

For FY 2004, the Administration is proposing to target resources in the following key areas:

Entitlement Programs:

- **Strengthening Services To Vulnerable Children Through An Innovative Child Welfare Program Option:** To strengthen services provided to these vulnerable children and further the goal of helping States develop a seamless system for child welfare services, ACF is proposing legislation to offer States an alternative to the current foster care entitlement program. Under this alternative system, States could choose to administer their foster care program within a fixed allocation of funds over a five year period if this approach would better support their unique child welfare needs. During this time, States would be given far greater flexibility in determining how best to use these funds in terms of services provided and populations served. The alternative program would encompass funding for the existing title IV-E foster care maintenance payments program and the associated administrative costs, including funding for the State Child Welfare Information Systems. Funding for the program would be cost neutral over five years. However, States would be able to receive up-front funding under the alternative option, and States that elect to use the alternative funding option and who experience emergencies affecting their foster care systems may apply for access to additional funding from the Temporary Assistance for Needy Families (TANF) Contingency Fund.
- **Improvements in the Child Support Enforcement Program to Increase Support to Families and to Increase Collections:** ACF is proposing legislation to enhance and expand the existing automated enforcement infrastructure at the Federal and State level and increase support collected on behalf of children and families. For example, proceeds from insurance settlements and gaming winnings will be subject to intercept for past due support and the process for freezing and seizing assets in multi-state financial institutions will be simplified at the Federal level. When combined with the opportunities to increase child support collections outlined in the President's FY 2003 budget (expanded passport denial, offset of certain Social Security benefits and mandatory review and adjustment of support orders) and the FY 2003 framework proposed for directing more of the support collected to children and families, over \$1 billion in increased support will be realized over five years as a result of the President's FY 2004 budget. Further, the FY 2004 budget request also recognizes that healthy families need more than financial support by seeking a \$2 million increase in funding for Access and Visitation grants to support and facilitate non-custodial parents access to and visitation with their children.

Discretionary Programs:

- **Increased LIHEAP Funding (+\$300 million):** In order to continue to provide home energy assistance, \$1,700,000,000 is requested for FY 2004, an increase of \$300,000,000 over the FY 2003 President's Budget. This increase will enable states to meet energy emergencies due to extremes in temperature, either during severe cold weather in the winter or sustained heat waves in the summer. This request will help enable states to meet the increasing demands for LIHEAP assistance, ensure that low income households are not without heating or cooling, and provide protection to our most vulnerable populations, the elderly, households with small children and persons with disabilities.
- **Strengthening Head Start (+\$148 million):** The budget request for FY 2004 is \$6,815,570,000, an increase of \$148 million over the FY 2003 President's budget request. This increase, coupled with greater discretionary authority to allocate resources contained in our proposed Head Start reauthorization, will be used to maintain current service levels and to increase the Head Start children enrollment in FY 2004. In the Head Start reauthorization, we are proposing to strengthen the program by eliminating some of the extremely prescriptive provisions that have been added to the statute over the years in order to provide greater flexibility to target the dollars where they are needed most. Of particular note, we are proposing to change the current statutory set-aside for training and technical assistance from at least two percent of the total appropriation to up to two percent of the total appropriation, providing the Secretary with greater discretionary authority to allocate these resources each year in a manner that would maximize benefits to children and families.
- **Mentoring Children of Prisoners (+\$25 million):** This newly authorized Administration initiative would provide \$50,000,000 – an increase of \$25 million above the FY 2003 President's Budget level – to provide competitive grants to State and local governments, Indian tribes and consortia, and faith and community-based organizations to mentor children of prisoners and those recently released from prison. The arrest and incarceration of a parent often results in traumatic separations for children, followed frequently by erratic shifts from one caregiver to another. These children are less likely than their peers to succeed in school and more likely to succumb to substance abuse, gangs, early childbearing, and delinquency. Children of incarcerated mothers are particularly vulnerable, as these children typically come from households where the mother was the sole provider, making placement in foster care more likely when the mother is in prison.
- **Additional Funding for the Domestic Violence Hotline (+\$843,000):** The FY 2004 request for the Domestic Violence Hotline is \$3,000,000, an increase of \$843,000 over the FY 2003 President's Budget. The increase addresses the need to answer more calls as well as to position the Hotline to properly respond to the "spike" in calls as various broadcast and public awareness activities impact their call numbers. The Hotline averages 300 to 400 calls a day; a response to a public awareness message or a program that publicizes the Hotline number can provide a "spike" of 400 to 500 calls within hours.

- **Targeted Reductions in the Community Services Block Grant, Rural Community Facilities Program, and Community Food and Nutrition Program (-\$88 million):** The budget request for FY 2004 reflects a lack of strong performance data for the CSBG program. The proposed reauthorization legislation includes measures that would generate more consistent performance data in future years for this program, and also ensure more accountability. Under this legislative proposal, non-performing grantees would lose their designation and be subject to a state-run award competition. In addition, funding is not requested for the Community Food and Nutrition Program and the Rural Community Facilities Program since these programs duplicate services provided by other programs.

STRATEGIC GOALS AND ACCOMPLISHMENTS

ACF is committed to working with our partners to focus on results by measuring performance and holding ourselves accountable to achieving results. Under the requirements of the Government Performance and Results Act and within the framework of Departmental goals, ACF strategic goals, objectives, and performance measures have been developed. The priorities reflected in the FY 2004 budget are in support of the four strategic goals in the ACF performance plan:

To accomplish this mission, ACF strives to achieve the following four strategic goals:

- **Strategic Goal 1 – Increase economic independence and productivity for families:** ACF assists families, particularly the most vulnerable, in achieving economic self-sufficiency and providing for their children's well-being. Key objectives include supporting job preparation and work, providing opportunities for independent living, ensuring parental responsibility, and offering child care subsidies targeted primarily to low-income families.
- **Strategic Goal 2 – Improve healthy development, safety and well-being of children and youth:** ACF invests in opportunities for children and youth to enjoy stable, safe and healthy years of growth, enabling them to become successful learners and productive adults. Primary outcomes include healthy marriages, safe environments, school readiness, and positive youth development.
- **Strategic Goal 3 – Increase the health and prosperity of communities and Tribes:** ACF believes that supportive communities and Tribes help families succeed. With its partners – including faith- and community-based organizations, private organizations, and State and local government – ACF is committed to supporting strategies that build strong, stable and supportive communities.
- **Strategic Goal 4 – Manage resources to improve performance:** ACF understands that positive outcomes for individuals, families and communities can be achieved through building a more effective organization and has aligned its management objectives with the President's Management Agenda and the HHS Strategic Plan. Major initiatives are underway in the areas of human capital, organizational development, electronic government and financial management.

The FY 2004 Performance Plan identifies the performance measures that we will use to track our progress toward achieving strategic goals. The FY 2002 Performance Report highlights the fact that ACF made significant progress in such areas as: (1) helping to improve the economic independence of low-income families; (2) continuing to promote access to quality child care services to help low-income working parents and their children; (3) increasing parental involvement and financial support of non-custodial parents in the lives of their children; (4) improving the healthy development and learning readiness of preschool children; and (5) increasing the safety and security of youth.

**ALL-PURPOSE TABLE – FISCAL 2002-2004
ADMINISTRATION FOR CHILDREN AND FAMILIES**

	2002 Enacted	2003 President's Budget	2004 Estimate¹
DISCRETIONARY PROGRAMS:			
LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP):			
LIHEAP Block Grant	1,700,000,000	1,400,000,000	1,700,000,000
Contingency Fund (LIHEAP)	300,000,000	300,000,000	300,000,000
Total, LIHEAP - Program Level	2,000,000,000	1,700,000,000	2,000,000,000
CHILD CARE & DEVELOPMENT BLOCK GRANT:			
Child Care & Development Block Grant	2,089,970,000	2,089,994,000	2,089,865,000
Research and Evaluation Fund	9,972,000	10,000,000	9,864,000
Total, Child Care & Development Block Grant	2,099,942,000	2,099,994,000	2,099,729,000
PROMOTING SAFE & STABLE FAMILIES: (Discretionary portion Only)			
Promoting Safe and Stable Families	69,997,000	200,000,000	199,978,000
Mentoring Children of Prisoners	0	25,000,000	50,000,000
Total, Promoting Safe & Stable Families	69,997,000	225,000,000	249,978,000
Independent Living Training Vouchers	0	60,000,000	60,000,000
CHILDREN & FAMILIES SERVICES PROGRAMS:			
Head Start			
Current Funded	5,136,977,000	5,267,533,000	5,415,570,000
Advance Funding	1,400,000,000	1,400,000,000	1,400,000,000
Subtotal, Head Start	6,536,977,000	6,667,533,000	6,815,570,000
Early Learning Opportunities Fund	24,988,000	0	0
Runaway and Homeless Youth Program:			
Runaway and Homeless Youth Program	88,024,000	88,133,000	88,043,000
Maternity Group Homes	0	10,000,000	10,000,000
Subtotal, Runaway and Homeless Youth Programs	88,024,000	98,133,000	98,043,000
Education & Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth	14,999,000	14,999,000	14,999,000
Child Abuse Programs:			
Child Abuse State Grants	22,013,000	22,013,000	22,013,000
Child Abuse Discretionary Activities	26,081,000	26,351,000	26,301,000
Community-Based Family Resource and Support Grants	33,412,000	33,417,000	33,403,000
Subtotal, Child Abuse Programs	81,506,000	81,781,000	81,717,000

¹ Reductions in the aggregate level of information technology spending in FY 2004 across ACF have resulted in small reductions in those discretionary accounts in which such spending is incurred. Where that is the case, our discussion of the change from the FY 2003 President's Budget request in the budget justification will only address changes exclusive of the IT reductions.

	2002 Enacted	2003 President's Budget	2004 Estimate ¹
Child Welfare Programs:			
Child Welfare Services	291,986,000	291,986,000	291,986,000
Child Welfare Training	7,487,000	7,498,000	7,470,000
Adoption Opportunities	27,335,000	27,405,000	27,343,000
Abandoned Infants Assistance Programs	12,194,000	12,205,000	12,086,000
Subtotal, Child Welfare Programs	339,002,000	339,094,000	338,885,000
Adoption Incentives	43,000,000	43,000,000	43,000,000
Children's Health Act Program			
Infant Adoption Awareness Program	9,906,000	9,906,000	9,906,000
Special Needs Adoption Program	3,000,000	3,000,000	3,000,000
Subtotal, Children's Health Act Program	12,906,000	12,906,000	12,906,000
Developmental Disabilities:			
Basic State Grants	69,800,000	69,800,000	69,800,000
Protection and Advocacy	35,000,000	35,000,000	35,000,000
Projects of National Significance	11,684,000	11,734,000	11,642,000
Centers for Excellence	24,000,000	24,000,000	24,000,000
Subtotal, Developmental Disabilities	140,484,000	140,534,000	140,442,000
Native American Programs	45,826,000	45,196,000	45,119,000
Social Services Research & Demonstration	30,918,000	6,000,000	5,982,000
Compassion Capital Fund	29,949,000	100,000,000	100,000,000
Promotion and Support of Responsible Fatherhood and Healthy Marriage	0	20,000,000	20,000,000
Federal Administration	171,466,000	171,837,000	179,584,000
Center for Faith Based and Community Initiatives	1,497,000	1,500,000	1,400,000
Subtotal, Federal Administration	172,963,000	173,337,000	180,984,000
Total FTE ²	1,465	1,512	1,472
Subtotal, Children and Families Services Programs	7,561,542,000	7,742,513,000	7,897,647,000
Community Services Programs:			
Community Services Block Grant	649,967,000	570,000,000	494,964,000
Community Services Discretionary Activities:			
JOLI	5,500,000	5,500,000	5,497,000
Community Economic Development	26,976,000	27,017,000	26,939,000
Rural Community Facilities	7,000,000	6,161,000	0
National Youth Sports	17,000,000	0	0
Community Food & Nutrition	7,312,000	6,657,000	0
Individual Development Accounts	24,943,000	24,990,000	24,912,000
Subtotal, Community Services Programs	738,698,000	640,325,000	552,312,000

² FY 2002 is shown comparably to reflect the transfer of the Unaccompanied Alien Children Program from the Immigration and Naturalization Service (17 FTE in all three years).

	2002 Enacted	2003 President's Budget	2004 Estimate ¹
Violent Crime Reduction:			
Family Violence Prevention and Support/Battered			
Women's Shelters	124,459,000	124,459,000	124,423,000
Domestic Violence Hotline	2,157,000	2,157,000	3,000,000
Subtotal, Violent Crime Reduction	126,616,000	126,616,000	127,423,000
Total, Children & Families Services Programs	8,426,856,000	8,509,454,000	8,577,382,000
REFUGEE AND ENTRANT ASSISTANCE:			
Transitional and Medical Services	227,243,000	227,291,000	200,193,000
Victims of Trafficking	10,000,000	10,000,000	10,000,000
Social Services	158,600,000	151,121,000	153,121,000
Victims of Torture	10,000,000	10,000,000	10,000,000
Preventive Health	4,835,000	4,835,000	4,835,000
Targeted Assistance	49,477,000	49,477,000	49,477,000
Unaccompanied Alien Children	33,000,000	33,000,000	34,000,000
Total, Refugee and Entrant Assistance, B.A.	493,155,000	485,724,000	461,626,000
Subtotal, ACF Discretionary Programs, B.A.	13,089,950,000	13,080,172,000	13,448,715,000
ENTITLEMENT PROGRAMS:			
PAYMENTS TO STATES FOR CHILD SUPPORT ENFORCEMENT			
& FAMILY SUPPORT PROGRAMS:			
State Child Support Administrative Costs	3,481,336,000	3,711,353,000	4,035,270,000
Federal Incentive Payments to States	450,000,000	461,000,000	454,000,000
CSE Hold Harmless Payments	0	10,0154,000	0
Access and Visitation Grants	10,000,000	10,000,000	12,000,000
Subtotal, Child Support Enforcement	3,941,336,000	4,192,507,000	4,501,270,000
Payments to territories	23,000,000	23,000,000	23,000,000
Repatriation	834,000	1,000,000	1,000,000
Subtotal, Other Payments	23,834,000	24,000,000	24,000,000
AFDC/Emergency Assistance	124,008,000	10,000,000	0
State and Local Welfare Administration	3,052,000	0	0
Subtotal, AFDC Programs	127,060,000	10,000,000	0
Total, Payments to States for CSE & FS Programs, Obligations	4,092,230,000	4,226,507,000	4,525,270,000
Payments to States for CSE & FS Programs, Net B.A.	3,846,518,000	4,036,800,000	4,345,970,000
PAYMENTS TO STATES FOR FOSTER CARE & ADOPTION ASSISTANCE:			
Foster Care	5,055,492,000	4,736,000,000	4,974,200,000
Independent Living	140,000,000	140,000,000	140,000,000
Adoption Assistance	1,426,000,000	1,619,800,000	1,699,700,000
Total, Payments to States for Foster Care and Adoption Assistance, B.A.	6,621,492,000	6,495,800,000	6,813,900,000
SOCIAL SERVICES BLOCK GRANT:			
B.A.	1,700,000,000	1,700,000,000	1,700,000,000
PROMOTING SAFE & STABLE FAMILIES:			
B.A.	304,989,000	305,000,000	305,000,000

	2002 Enacted	2003 President's Budget	2004 Estimate ¹
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF):			
State Family Assistance Grants	16,488,667,000	16,488,667,000	16,488,667,000
Territories – Family Assistance Grants	77,875,000	77,875,000	77,875,000
Matching Grants to Territories	15,000,000	15,000,000	15,000,000
Supplemental Grants for Population Increases	319,450,000	319,450,000	319,450,000
Contingency Fund	0	2,000,000,000	[2,000,000,000]
Bonus to Reward Decrease in Illegitimacy	100,000,000	0	0
Employment Achievement (formerly High Performance) .	[200,000,000]	[300,000,000]	500,000,000
Tech Asst & Welfare Research - Family Formation	0	100,000,000	100,000,000
Family Formation Grants	0	[100,000,000]	100,000,000
Native Employment Works Program	7,633,000	7,633,000	7,633,000
Total, TANF, B.A. Current Law	17,008,625,000	19,008,625,000	17,608,625,000
CHILDREN'S RESEARCH & TECHNICAL ASSISTANCE:			
Training & Technical Assistance	12,317,545	11,790,000	11,560,000
Federal Parent Locator Service	24,609,089	23,580,000	23,120,000
Children's Welfare Research	0	15,000,000	15,000,000
Total, Children's Research & Technical Assistance, B.A. ...	36,926,634	50,370,000	49,680,000
CHILD CARE ENTITLEMENT TO STATES:			
Mandatory	1,177,524,781	1,177,524,781	1,177,524,781
Matching	1,478,342,719	1,478,342,719	1,478,342,719
Training & Technical Assistance	6,792,500	6,792,500	6,792,500
Tribal Mandatory Funds	54,340,000	54,340,000	54,340,000
Total, Child Care Entitlement, B.A.	2,717,000,000	2,717,000,000	2,717,000,000
TOTAL, ENTITLEMENT PROGRAMS, B.A.	12,472,999,000	12,537,600,000	13,164,870,000
TOTAL, PRE-APPROPRIATED PROGRAMS, B.A....	19,762,551,634	21,775,995,000	20,375,305,000
TOTAL, DISCRETIONARY PROGRAMS, B.A.....	13,089,950,000	13,080,172,000	13,448,715,000
TOTAL, ACF PROGRAMS, B.A.	45,325,500,634	47,393,767,000	46,988,890,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Payments to States for Child Support Enforcement and Family Support Programs

<u>FY 2004 Budget</u>	<u>Page</u>
Appropriation Language	B-2
Amounts Available for Obligation	B-3
Summary of Changes	B-4
Budget Authority by Activity	B-6
Budget Authority by Object	B-7
Significant Items in House, Senate, and Conference Appropriation Committee Reports	B-8
Authorizing Legislation	B-10
Appropriations History Table	B-11
Justification:	
General Statement	B-12
Child Support Enforcement	B-15
Other Programs	B-27
Prior Year AFDC and Related Programs	B-31

PAYMENTS TO STATES FOR CHILD SUPPORT ENFORCEMENT
AND FAMILY SUPPORT PROGRAMS

For making payments to States or other non-Federal entities under titles I, IV-D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch. 9), [\$2,936,800,000] \$3,292,970,000, to remain available until expended; and for such purposes for the first quarter of fiscal year [2004, \$1,100,000,000] 2005, \$1,200,000,000, to remain available until expended.

For making payments to each State for carrying out the program of Aid to Families with Dependent Children under title IV-A of the Social Security Act before the effective date of the program of Temporary Assistance to Needy Families (TANF) with respect to such State, such sums as may be necessary: *Provided*, That the sum of the amounts available to a State with respect to expenditures under such title IV-A in fiscal year 1997 under this appropriation and under such title IV-A as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not exceed the limitations under section 116(b) of such Act .

For making, after May 31 of the current fiscal year, payments to States or other non-Federal entities under titles I, IV-D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch. 9), for the last 3 months of the current fiscal year for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2003, as proposed by the FY 2003 President's Budget

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Payments to States for Child Support Enforcement and Family Support Programs

Amounts Available for Obligation

	<u>2002</u> <u>Actual</u>	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>
Appropriation:			
Current Year.....	\$2,447,800,000	\$2,936,800,000	\$3,245,970,000
Advance.....	1,000,000,000	1,100,000,000	1,100,000,000
Indefinite.....	398,718,000	0	0
Subtotal, net budget authority.....	3,846,518,000	4,036,800,000	4,345,970,000
Offsetting collections	157,452,000	189,454,000	179,300,000
Subtotal, gross budget authority.....	4,003,970,000	4,226,254,000	4,525,270,000
Unobligated balance start of year.....	88,513,000	253,000	0
Recovery of prior year obligations.....	0	0	0
Unobligated balance end of year.....	253,000	0	0
Total Obligations.....	\$4,092,230,000	\$4,226,507,000	\$4,525,270,000

Payments to States for Child Support Enforcement and Family Support Programs

SUMMARY OF CHANGES

FY 2003 President's Budget Request		
Total estimated budget authority.....		\$4,226,254,000
(Obligations)		4,226,507,000
FY 2004 Estimate.....		
(Obligations)		4,525,270,000
Net change.....		+299,016,000
(Obligations)		+298,763,000

	2003 President's <u>Budget Base</u>	<u>Change from Base</u>
Increases:		
<u>Built-in:</u>		
Increase in Child Support Enforcement Administrative costs.....	\$3,711,353,000	+\$372,917,000
Increase due to reduction of unobligated balances carried forward.....	253,000	+253,000
<u>Program:</u>		
Increase in Access and Visitation Grants to States	10,000,000	+2,000,000
Total Increases		<u>+\$375,170,000</u>
Decreases:		
<u>Built-in:</u>		
Decrease in amount available for incentive payments to States.....	461,000,000	-7,000,000
<u>Program:</u>		

Decrease in administrative costs due to legislative proposals.....	3,711,353,000	-49,000,000
Expiration of provision providing hold harmless payments to States.....	10,154,000	-10,154,000
Decrease in payments for prior-year claims for AFDC and related programs repealed by P.L. 104-193.....	10,000,000	-10,000,000
Total Decreases		<u>-76,154,000</u>
Net Change.....		<u>-\$299,016,000</u>

Payments to States for Child Support Enforcement and Family Support Programs

Budget Authority by Activity
(Obligations)

	<u>2002</u> <u>Actual</u>	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>
CHILD SUPPORT ENFORCEMENT:			
State Child Support Administrative costs.....	\$3,481,336,000	\$3,711,353,000	\$4,035,270,000
Federal Incentive Payments to States	450,000,000	461,000,000	454,000,000
Hold Harmless Payments to States	0	10,154,000	0
Access and Visitation Grants.....	<u>10,000,000</u>	<u>10,000,000</u>	<u>12,000,000</u>
Subtotal, Child Support Enforcement	3,941,336,000	4,192,507,000	4,501,270,000
OTHER PROGRAMS			
Payments to Territories – Adults..	23,000,000	23,000,000	23,000,000
Repatriation	<u>834,000</u>	<u>1,000,000</u>	<u>1,000,000</u>
Subtotal, Other Programs	23,834,000	24,000,000	24,000,000
PRIOR-YEAR AFDC AND RELATED PAYMENTS:			
AFDC/EA payments	124,008,000	10,000,000	0
State and Local Welfare Administration.....	<u>3,052,000</u>	<u>0</u>	<u>0</u>
Subtotal, AFDC Programs.....	127,060,000	10,000,000	0
Total Obligations.....	\$4,092,230,000	\$4,226,507,000	\$4,525,270,000

Payments to States for Child Support Enforcement and Family Support Programs

Budget Authority by Object
(Obligations)

	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
Grants, subsidies and contributions	\$4,226,507,000	\$4,525,270,000	+\$298,763,000
Total obligations	\$4,226,507,000	\$4,525,270,000	+\$298,763,000

ADMINISTRATION FOR CHILDREN AND FAMILIES

Payments to States for Child Support Enforcement and Family Support Programs

SIGNIFICANT ITEMS IN HOUSE, SENATE AND CONFERENCE
APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2003 Congressional requirements for reports and significant items derived from Senate Report 107-216 (Labor, Health and Human Services and Education). These actions discussed below are contingent on inclusion of similar language and funding in the final FY 2003 appropriation and related reports. Additional items may be transmitted at a later date as a result of the final Conference report.

2003 Senate Committee Report LanguageItem

[State information technology consortium] The Committee four years ago encouraged ACF to work with the State information technology consortium in an effort to help States with the difficult task of streamlining service delivery, while also meeting TANF record keeping and reporting requirements. The Committee is pleased to learn that this effort is progressing and that States and ACF are now able to share systems information on TANF, child support enforcement, child welfare and child care activities. The Committee understands that plans are now underway to put in place web-based technology that permits communications and interface within States, across State borders, and between ACF and States. Accordingly, the Committee urges ACF to expand its efforts with the State information technology consortium in fiscal year 2003. Similarly, the Committee is pleased to note that child support collections on behalf of families continue to grow. When combined with other income, child support collections passed through to TANF families can provide the boost needed to help a family attain self-sufficiency. To aid in this objective, the Committee urges CSE to implement the next phase of an effort launched last year in conjunction with the State information technology consortium. The Committee remains convinced that States are in a position to best determine how to remove current barriers to child support collections and to improve the flow of information between agencies and the court system.

Action Taken or to be Taken

In FY 2002, OCSE contracted with State Information Technology Consortium (SITC) to help child support enforcement efforts by improving coordination and the flow of data between State IV-D Agencies, tribal organizations and State Courts. These joint efforts with SITC included: researching and collecting best practices from State IV-D agencies in the area of internet and web-based customer service capabilities, developing a best practices training curriculum and resource CD-ROM in the area of web-based customer service for child support clients, and conducting four training sessions on Child Support web development which were held throughout the United States. Ongoing activities in

2003 include a training session in Dallas, Texas in January 2003, and another training session in Seattle, Washington in March 2003. Another effort involved the establishment and facilitation of a Tribal CSE Systems workgroup, and an interstate workgroup on tribal and State child support agency intergovernmental cooperation. A feasibility study for a data and document exchange capability between the State child support agencies and their court systems is underway and SITC will provide support at the National Judicial symposium on Children, Courts and the Child Support Enforcement program. SITC has also provided research and analysis support for Child Support Enforcement Automated systems reviews, and support for an Interstate workgroup on interagency data access. OCSE plans to implement the next steps in these efforts in FY 2003.

Payments to States for Child Support Enforcement and Family Support Programs

Authorizing Legislation

	<u>2003 Amount Authorized</u>	<u>2003 President's Budget</u>	<u>2004 Amount Authorized</u>	<u>2004 Budget Request</u>
Payments to States for Child Support Enforcement and Family Support Programs: Titles I, IV-A and -D, X, XI, XIV and XVI of the Social Security Act and the Act of July 5, 1960 (Public Law 86- 571)				
Total Appropriation, Net budget authority	Indefinite ¹	\$4,036,800,000	Indefinite ¹	\$4,345,970,000

¹ Generally, indefinite authority is authorized for this account; however, there are specific authorizations for a few of the programs covered by this appropriation:

- Section 1108(a) of the Social Security Act provides for a limitation on payment to Puerto Rico, Guam and the Virgin Islands under titles I, X, XIV, XVI, parts A and E of title IV and subsection 1108(b)(Matching grants). The limitations were established by P.L. 104-193 and most recently amended by Section 5512 of P.L. 105-33, are as follows: \$107,255,000 for Puerto Rico, \$3,554,000 for the Virgin Islands \$4,686,000 for Guam, and \$1,000,000 for American Samoa. The limitations do not apply however to the Bonus to Reward the Decrease in Illegitimacy, the Bonus to Reward High Performance States, or Loans for State Welfare Programs.
- Section 1113 of the Social Security Act provides for a \$1,000,000 limitation on funds paid to repatriated U.S. citizens and dependents that return because of destitution, illness or international crisis.
- Access and Visitation Grants are authorized by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L.104-193) for \$10,000,000 for each fiscal year.

Payments to States for Child Support Enforcement and Family Support Programs

APPROPRIATIONS HISTORY TABLE

<u>Year</u>	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1994	\$15,915,966,000	\$15,915,966,000	\$15,915,966,000	\$15,915,966,000
1995	16,961,788,000	16,961,788,000	16,961,788,000	16,961,788,000
1996	18,014,307,000	18,014,307,000	18,014,307,000	18,014,307,000
1997	18,101,000,000	18,101,000,000	18,101,000,000	6,958,000,000 ⁴
1998	607,000,000	607,000,000	607,000,000	607,000,000 ⁵
1999	2,648,794,000	2,648,794,000	2,648,794,000	2,648,794,000 ⁶
2000	750,000,000	750,000,000	750,000,000	1,010,248,000 ⁷
2001	3,091,800,000	3,091,800,000	3,091,800,000	3,091,800,000
2002	3,447,800,000	3,447,800,000	3,447,800,000	3,846,518,000 ⁸
2003	4,036,800,000 ¹			
2004	4,345,970,000 ²			
2005	1,200,000,000 ³			

¹ Amount requested to finance estimated obligations including \$1,100,000,000 advance appropriation.² Amount requested to finance estimated obligations including \$1,100,000,000 advance appropriation.³ Requested advance for first quarter.⁴ Sum of the FY 97 advance appropriation of \$4,800,000,000 and the FY 97 appropriation for child support enforcement of \$2,158,000,000 due to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 creating TANF.⁵ Advance appropriation only. Due to the unobligated balance carryover from FY 97 to FY 98 and the advance appropriation for the first quarter, an appropriation was not needed to finance obligations.⁶ Amount appropriated consisting of the \$660,000,000 advance appropriation and the appropriated amount of \$1,988,794,000.⁷ The first three columns include the advance appropriation only. The last column includes \$260,248,000 in indefinite authority used to finance obligations.⁸ The last column includes \$398,718,000 in indefinite authority used to finance obligations.

Payments to States for Child Support Enforcement and Family Support Programs

Justification
(Obligations)

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
<u>Child Support Enforcement:</u>				
State Child Support Administrative Costs	\$3,481,336,000	\$3,711,353,000	\$4,035,270,000	+\$323,917,000
Federal Incentive Payments to States	450,000,000	461,000,000	454,000,000	-7,000,000
Hold Harmless Payments to States	0	10,154,000	0	-10,154,000
Access and Visitation	<u>10,000,000</u>	<u>10,000,000</u>	<u>12,000,000</u>	<u>+2,000,000</u>
Subtotal, CSE	3,941,336,000	4,192,507,000	4,501,270,000	+308,763,000
<u>Other Programs:</u>				
Payments to territories	23,000,000	23,000,000	23,000,000	0
Repatriation	<u>834,000</u>	<u>1,000,000</u>	<u>1,000,000</u>	<u>0</u>
Subtotal, other programs	23,834,000	24,000,000	24,000,000	0
<u>Prior Year AFDC & Related Payments:</u>				
AFDC Benefits Payments	124,008,000	10,000,000	0	-10,000,000
AFDC Administration	<u>3,052,000</u>	<u>0</u>	<u>0</u>	<u>0</u>
Subtotal, Prior Year AFDC	127,060,000	10,000,000	0	-10,000,000
Total Gross Obligations	4,092,230,000	4,226,507,000	4,525,270,000	+298,763,000
Spending authority from Offsetting Collections ¹	<u>-157,452,000</u>	<u>-189,454,000</u>	<u>-179,300,000</u>	<u>-10,154,000</u>
Total Net Obligations	\$3,934,778,000	\$4,037,053,000	\$4,345,970,000	+\$308,917,000

¹ State alternative systems penalties paid by check instead of grant offset. Penalties are used to offset budget authority required to pay grants.

General Statement

The Payments to States for Child Support Enforcement and Family Support Programs support State-administered programs of financial assistance and supportive services for low-income families to promote their economic security and self-sufficiency. In FY 2004 four programs will be funded:

- State administrative expenses for Child Support Enforcement;
- Access and Visitation grants to enable States and tribes to establish and administer programs to support and facilitate non-custodial parents' access to and visitation of their children;
- Payments for adult-only benefits under assistance programs for the aged, blind and disabled residents of Guam, Puerto Rico, the Virgin Islands, and American Samoa; and
- Repatriation of American citizens and dependents returned from foreign countries as a result of illness, destitution, war or other crisis, who need temporary cash and services.

Legislation will be proposed under the Child Support Enforcement Program to enhance and expand the existing automated enforcement infrastructure at the federal and State level and increase support collected on behalf of children and families. Proceeds from insurance settlements and gaming winnings will be subject to intercept for past due support; a loophole will be closed to allow garnishment of longshoremen's benefits; and, the process for freezing and seizing assets in multi-state financial institutions will be simplified at the federal level. When combined with the opportunities to increase child support collections outlined in the President's FY 2003 budget (expanded passport denial, offset of certain Social Security benefits and mandatory review and adjustment of support orders) and the FY 2003 framework proposed for directing more of the support collected to children and families, over \$1 billion in increased support will be realized over five years as a result of the President's FY 2004 budget.

The budget also recognizes that healthy families need more than financial support alone and increases resources for Access and Visitation Programs to support and facilitate non-custodial parents' access to and visitation of their children.

Finally, legislation will be proposed to make technical changes to the program including changes to remove certain statutory impediments to effective tribal child support enforcement programs.

Effects of Proposed Legislation

The President's FY 2004 Budget request of \$4.346 billion reflects current law of \$4.393 billion adjusted by -\$0.047 billion assuming Congressional action on proposed legislation as follows:

- Federal Seizure of Accounts in Multi-State Financial Institutions (MSFIDM)

Description: This proposal would provide federal authority to freeze and seize assets in accounts held in multi-state financial institutions to satisfy child support obligations. This new enforcement tool would result in an estimated \$528 million additional collections to families over five years.

- **Require Intercept of Gaming Proceeds**

Description: This proposal would require States and tribal CSE programs to intercept gaming winnings. When gambling winners meet the threshold for IRS reporting, gaming establishments will be required to check a secure web site and offset any owed child support from winnings. Gaming establishments would be authorized to retain up to two percent of the offset amount to recoup their operational costs. This new enforcement tool would result in an estimated \$709 million additional collections to families over five years.

- **Provide for Garnishment of Longshore and Harbor Worker's Compensation Benefits**

Description: This proposal would expand the federal garnishment authority for child support debts to be collected through withholding of federal benefits paid for persons working in shipyards, docks and ships. This new enforcement tool would result in an estimated \$86 million additional collections to families over five years.

- **FPLS Access to Insurance Settlement Databases**

Description: This proposal would expand the Federal Parent Locator Service to allow matches with pending insurance claims and settlement databases in order to assist States in identifying claimants who owe past-due support. This new enforcement tool would result in an estimated \$101 million additional collections to families over five years.

- **Increased Funding for Access and Visitation State Grant Program**

Description: This proposal would gradually increase the current funding of \$10 million for these grants to \$20 million by FY 2007 and direct a portion of the increase to tribes operating child support programs under title IV-D of the Act. It is estimated that State and tribal efforts as the result of these additional grants could provide \$14 million in new collections to families over five years.

- **Direct Access for Indian Tribes to the Federal Income Tax Refund Offset Program and the Federal FPLS**

Description: This proposal would allow tribes receiving direct federal child support grants access to federal enforcement and location systems critical to the effective operation of the child support program. It is estimated that this access could result in \$101 million in additional collections to tribal families over five years.

These legislative proposals build on the legislative base established under welfare reform and expanded under the President's FY 2003 budget.

CHILD SUPPORT ENFORCEMENT

Authorizing Legislation – Title IV-D of the Social Security Act, as amended.

	2002 Actual	2003 President's Budget	2004 Estimate	Increase Or Decrease
State Child Support Administrative Costs	\$3,481,336,000	\$3,711,353,000	\$4,035,270,000	+323,917,000
Federal Incentive Payments to States	450,000,000	461,000,000	454,000,000	-7,000,000
Hold Harmless Payments to States ¹	0	10,154,000	0	-10,154,000
Access and Visitation Grants	<u>10,000,000</u>	<u>10,000,000</u>	<u>12,000,000</u>	<u>+2,000,000</u>
Total Obligations	\$3,941,336,000	\$4,192,507,000	\$4,501,270,000	+\$308,763,000

2004 Authorization....Such sums.

Purpose and Method of Operation**Child Support Enforcement**

The Child Support Enforcement program (CSE) is a federal/State effort to foster family responsibility and promote self-sufficiency by ensuring that both parents support children financially and emotionally. It reduces the need for public assistance and its cost to the taxpayers. CSE agencies locate non-custodial parents, establish paternity when necessary, and establish and enforce orders for support. CSE services are available to all people with custody of a child who has a parent living outside of the home.

The Administration for Children and Families' (ACF) strategic goal of increasing economic independence and productivity for families is dependent upon a strategy of increasing income through the enforcement of child support.

¹ The Hold Harmless provision was enacted, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), to provide that the Federal government would make up the difference if the State share of Temporary Assistance for Needy Families (TANF) collections falls below their FY 95 levels. The Foster Care Independence Act (P.L. 106-169) narrowed these payments for FY 1999 and FY 2000 and repealed them effective October 1, 2001. The final payment for FY 2001 was made during FY 2003.

The program strengthens families by helping children get the support they are owed from non-custodial parents. By securing support from non-custodial parents on a consistent and continuing basis, families may avoid the need for publicly funded assistance, thus reducing government spending. In non-TANF cases, child support collections are forwarded to the custodial family. Applicants for TANF assign their rights to support payments to the State as a condition of receipt of assistance. Child support collections in TANF cases are shared between the State and federal governments, reducing taxpayer costs. Some States choose to pass through a portion of a TANF family's child support collections to the family and disregard these payments in determining eligibility or amount of assistance. A portion of the federal share of child support collections is paid to the States as incentive payments. Incentive payments are based on State performance in paternity establishment, order establishment, collection of current support and arrears in addition to cost effectiveness.

The federal government provides funding in several ways: a 66 percent match rate for general State administrative costs; a 90 percent match rate for paternity testing; and funding of incentive payments (\$454 million for FY 2004).

Access and Visitation Grants

This grant program was created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Funding began in FY 1997 with a capped entitlement of \$10 million. Every Governor has designated a State agency that will use these grant funds to establish and administer programs to support and facilitate non-custodial parents' access to and visitation of their children. Activities which may be funded include: mediation (both voluntary and mandatory), counseling, education, development of parenting plans, visitation enforcement (including monitoring, supervision and neutral drop-off and pick-up), and development of guidelines for visitation and alternative custody arrangements. The funding is separate from funding for federal and State administration of the Child Support Enforcement program.

Rationale for the Budget Request

The Child Support Enforcement program collected \$20 billion in FY 2002, serving an estimated 17.1 million-child support cases. Since the creation of the Child Support Enforcement program, child support collections within the program have grown annually. States have increased collections by using a wide variety of approaches such as income withholding, offset of income tax refunds, support guidelines and reporting to credit bureaus. In addition, States are beginning to reap the benefits of the tools provided by PRWORA.

- The government collected a record \$1.6 billion in overdue child support from federal income tax refunds for tax year 2001. More than 2.2 million families benefited from these collections.
- A program to match a list of delinquent parents with financial institution records found over 1.4 million accounts belonging to more than 854,000 delinquent non-custodial parents nationwide with a value in excess of \$3.2 billion.

- The number of paternities established or acknowledged was almost 1.6 million in FY 2001. Of these, over 791,000 were established through in-hospital acknowledgement programs.
- Voluntary State reports indicate that the Passport Denial program resulted in collections of over \$4.6 million in lump sum child support payments in FY 2001.
- Using the expanded Federal Parent Locator Services, OCSE was able to provide States information on over four million non-custodial parents and putative fathers.

ACF will measure the CSE program's success using the outcome measures, which are part of the new incentive system to gauge the achievement of the goals and objectives of the National CSE Strategic Plan. The measures for FY 2004 are:

- The paternity establishment percentage will increase from 98 percent to 99 percent from FY 2003 to FY 2004 – This measure directly indicates achievement of the performance target by comparing paternities established during the fiscal year with the number of non-marital births during the preceding fiscal year. The rate above includes paternities established by the IV-D program and paternities established by hospital-based programs.
- The child support order establishment rate will be 70 percent for FY 2004 – A support order is needed to collect child support. This measure directly indicates achievement of the performance target by comparing the number of IV-D cases with support orders with the number of IV-D cases. With the establishment of new reporting requirements the caseload data has come into alignment and no longer reflects double counting of cases that fall into more than one category. Hence, our goal has been adjusted to reflect a more accurate case and order count.
- The collection rate for current support will be 60 percent for FY 2004 – This measure, which is a proxy for the regular and timely payment of support, directly indicates achievement of the performance target by comparing total dollars collected for current support in IV-D cases with total dollars owed for current support in IV-D cases.
- The percentage of cases with child support arrearages that pay some amount is projected to increase from the FY 2003 target of 56 percent to 60 percent in FY 2004 – This measure directly indicates achievement of the performance target by comparing the total number of IV-D cases paying any amount toward arrears with the total number of IV-D cases with arrears due.
- The cost-effectiveness ratio (total dollars collected per \$1 of expenditures) will be adjusted to \$4.35 for FY 2004 – This measure directly indicates achievement of the performance target by comparing total IV-D dollars collected by States with total IV-D dollars expended by States.

Impact of FY 2004 Legislative Proposals on Program and Families

The FY 2004 legislative proposals will increase the collections on behalf of families and as a result of the President's FY 2003 budget, direct more of this increased support collected to families. This will help move the program more towards a focus on families and away from the historic purpose of recoupment of federal and State outlays for welfare.

Proceeds from insurance settlements and gaming winnings will be subject to intercept for past due support; a loophole will be closed to allow garnishment of Longshoremen's benefits; and, the process for freezing and seizing assets in multi-state financial institutions will be simplified at the federal level. When combined with the opportunities to increase child support collections outlined in the President's FY 2003 budget (expanded passport denial, offset of certain Social Security benefits and mandatory review and adjustment of support orders) and the FY 2003 framework proposed for directing more of the support collected to children and families, \$2.6 billion in increased support to families will be realized over five years as a result of the President's FY 2004 budget.

The budget also recognizes that healthy families need more than financial support alone and increases resources for Access and Visitation Programs to support and facilitate non-custodial parents' access to and visitation of their children. States are serving a growing number of families with their access and visitation grants and "waiting lists" for services are growing. A portion of the increased amounts will be allocated to grants to tribes that have operated a Tribal Child Support Program for at least one year. This funding will not reduce the amount of funds available for State Access and Visitation programs.

Finally, legislation will be proposed to make technical changes to the program including changes to remove certain statutory impediments to effective tribal child support enforcement programs.

These changes build on pending child support enforcement legislation addressed in the President's FY 2003 budget to direct more support to families and increase collections as laid out above as well as charging a modest annual fee in certain cases with collections.

Child Support Enforcement Collections and Costs
(\$ in millions)

	2002	2003	2004	Increase
	<u>Actual</u>	<u>President's</u>	<u>Estimate</u>	<u>Or</u>
		<u>Budget</u>		<u>Decrease</u>
Total Collections Distributed to:				
Families	17,879	19,350	20,875	1,525
TANF Program	2,080	2,035	2,078	43
FC Program	49	52	54	2
Total	20,008	21,437	23,007	1,570
Distributed to TANF /FC Program:				
Federal Share	1,179	1,156	1,181	25
State Share	950	931	951	20
Total	2,129	2,087	2,132	45
Administrative Costs: (Obligations)				
Federal share	3,481	3,711	4,035	324
State Share	1,751	1,875	2,021	146
Total	5,232	5,586	6,056	470
Incentive Payments To States	450	461	454	-7
Program Costs: (Costs Minus Collections)				
Federal Costs	2,752	3,016	3,308	292
State Costs	351	483	616	133
Net Costs to Taxpayer	3,103	3,499	3,924	425

Resource and Program Data
State Child Support Administrative Costs
(Obligations)

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$3,481,336,000	\$3,711,353,000	\$4,035,270,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$3,481,336,000	\$3,711,353,000	\$4,035,270,000
Program Data:			
Number of Grants	62	62	70
New Starts:			
#			8
\$			\$17,000,000
Continuations:			
#	62	62	62
\$	\$3,481,336,000	\$3,711,353,000	\$4,018,270,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

Resource and Program Data
Federal Incentive and Hold Harmless Payments to States

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Incentive	\$450,000,000	\$461,000,000	\$454,000,000
Hold Harmless		10,154,000	
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$450,000,000	\$471,154,000	\$454,000,000
<u>Program Data:</u>			
Number of Grants	54	54	54
New Starts:			
#			
\$			
Continuations:			
#	54	54	54
\$	\$450,000,000	\$471,154,000	\$454,000,000
Contracts:			
#			
\$			

Resource and Program Data
Access and Visitation Grants

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$10,000,000	\$10,000,000	\$12,000,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$10,000,000	\$10,000,000	\$12,000,000
Program Data:			
Number of Grants	54	54	62
New Starts:			
#			8
\$			\$250,000
Continuations:			
#	54	54	54
\$	\$10,000,000	\$10,000,000	\$11,750,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Federal Share of State and Local Administrative Costs (CFDA # 93.563)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$42,479,531	\$45,503,762	\$48,598,542	\$3,094,780
Alaska	17,708,684	18,969,412	20,259,551	1,290,139
Arizona	46,231,118	49,522,434	52,890,531	3,368,097
Arkansas	34,803,557	37,281,315	39,816,874	2,535,559
California	643,480,803	689,291,910	736,171,714	46,879,804
Colorado	44,459,192	47,624,360	50,863,366	3,239,006
Connecticut	54,298,184	58,163,816	62,119,627	3,955,811
Delaware	15,469,619	16,570,942	17,697,958	1,127,016
District of Columbia	3,183,731	3,410,389	3,642,335	231,946
Florida	172,713,121	185,009,027	197,591,775	12,582,748
Georgia	80,262,008	85,976,074	91,823,439	5,847,365
Hawaii	9,673,204	10,361,865	11,066,591	704,726
Idaho	16,679,586	17,867,050	19,082,216	1,215,166
Illinois	142,773,083	152,937,478	163,338,991	10,401,513
Indiana	50,402,043	53,990,298	57,662,262	3,671,964
Iowa	42,156,745	45,157,996	48,229,260	3,071,264
Kansas	44,068,912	47,206,295	50,416,868	3,210,573
Kentucky	50,815,848	54,433,563	58,135,674	3,702,111
Louisiana	43,684,618	46,794,642	49,977,218	3,182,576
Maine	17,661,307	18,918,662	20,205,350	1,286,688
Maryland	74,097,686	79,372,897	84,771,170	5,398,273
Massachusetts	58,572,435	62,742,362	67,009,567	4,267,205
Michigan	299,030,967	320,319,776	342,105,215	21,785,439
Minnesota	106,446,756	114,024,983	121,779,998	7,755,015
Mississippi	16,506,678	17,681,832	18,884,401	1,202,569
Missouri	70,449,491	75,464,977	80,597,467	5,132,490
Montana	9,821,643	10,520,872	11,236,413	715,541
Nebraska	36,372,427	38,961,877	41,611,734	2,649,857
Nevada	28,637,956	30,676,768	32,763,142	2,086,374
New Hampshire	14,636,211	15,678,202	16,744,500	1,066,298
New Jersey	137,732,346	147,537,878	157,572,156	10,034,278
New Mexico	30,207,216	32,357,748	34,558,448	2,200,700
New York	217,214,792	232,678,890	248,503,739	15,824,849
North Carolina	79,217,325	84,857,017	90,628,273	5,771,256
North Dakota	9,139,614	9,790,287	10,456,140	665,853

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	304,021,054	325,665,120	347,814,105	22,148,985
Oklahoma	36,251,646	38,832,497	41,473,555	2,641,058
Oregon	40,441,915	43,321,082	46,267,416	2,946,334
Pennsylvania	140,172,505	150,151,758	160,363,809	10,212,051
Rhode Island	13,900,712	14,890,341	15,903,056	1,012,715
South Carolina	19,621,155	21,018,037	22,447,506	1,429,469
South Dakota	6,627,582	7,099,417	7,582,259	482,842
Tennessee	50,198,947	53,772,743	57,429,910	3,657,167
Texas	196,685,928	210,688,522	225,017,772	14,329,250
Utah	26,468,538	28,352,904	30,281,228	1,928,324
Vermont	6,143,808	6,581,202	7,028,800	447,598
Virginia	59,154,812	63,366,200	67,675,833	4,309,633
Washington	109,729,558	117,541,497	125,535,675	7,994,178
West Virginia	23,899,379	25,600,839	27,341,992	1,741,153
Wisconsin	60,764,149	65,090,110	69,516,989	4,426,879
Wyoming	7,509,046	8,043,635	8,590,695	547,060
Subtotal	3,862,679,171	4,137,673,560	4,419,083,105	281,409,545
Indian Tribes	6,133,178	11,700,000	34,800,000	23,100,000
Guam	4,032,022	4,319,072	4,612,819	293,747
Puerto Rico	23,383,775	25,048,528	26,752,117	1,703,589
Virgin Islands	3,515,557	3,765,840	4,021,959	256,119
Subtotal	37,064,532	44,833,440	70,186,895	25,353,455
Total States/Territories	3,899,743,703	4,182,507,000	4,489,270,000	306,763,000
ADJUSTMENTS:	31,592,297	0	0	0
Subtotal Adjustments	31,592,297	0	0	0
TOTAL RESOURCES	\$3,931,336,000	\$4,182,507,000	\$4,489,270,000	\$306,763,000

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Access and Visitation (CFDA # 93.597)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$146,610	\$146,610	\$171,044	\$24,434
Alaska	100,000	100,000	120,000	20,000
Arizona	154,416	154,416	180,153	25,737
Arkansas	100,000	100,000	120,000	20,000
California	970,431	970,431	1,132,168	161,737
Colorado	119,443	119,443	139,351	19,908
Connecticut	100,000	100,000	120,000	20,000
Delaware	100,000	100,000	120,000	20,000
District of Columbia	100,000	100,000	120,000	20,000
Florida	485,954	485,954	566,946	80,992
Georgia	274,295	274,295	320,011	45,716
Hawaii	100,000	100,000	120,000	20,000
Idaho	100,000	100,000	120,000	20,000
Illinois	345,253	345,253	402,796	57,543
Indiana	182,299	182,299	212,682	30,383
Iowa	100,000	100,000	120,000	20,000
Kansas	100,000	100,000	120,000	20,000
Kentucky	121,519	121,519	141,772	20,253
Louisiana	170,393	170,393	198,792	28,399
Maine	100,000	100,000	120,000	20,000
Maryland	172,830	172,830	201,635	28,805
Massachusetts	172,640	172,640	201,413	28,773
Michigan	312,971	312,971	365,133	52,162
Minnesota	128,014	128,014	149,350	21,336
Mississippi	111,014	111,014	129,516	18,502
Missouri	174,425	174,425	203,496	29,071
Montana	100,000	100,000	120,000	20,000
Nebraska	100,000	100,000	120,000	20,000
Nevada	100,000	100,000	120,000	20,000
New Hampshire	100,000	100,000	120,000	20,000
New Jersey	214,698	214,698	250,481	35,783
New Mexico	100,000	100,000	120,000	20,000
New York	606,330	606,330	707,385	101,055
North Carolina	248,098	248,098	289,447	41,349
North Dakota	100,000	100,000	120,000	20,000

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	356,353	356,353	415,745	59,392
Oklahoma	105,956	105,956	123,616	17,660
Oregon	100,000	100,000	120,000	20,000
Pennsylvania	333,852	333,852	389,494	55,642
Rhode Island	100,000	100,000	120,000	20,000
South Carolina	138,905	138,905	162,056	23,151
South Dakota	100,000	100,000	120,000	20,000
Tennessee	179,100	179,100	208,949	29,849
Texas	621,404	621,404	724,972	103,568
Utah	100,000	100,000	120,000	20,000
Vermont	100,000	100,000	120,000	20,000
Virginia	203,537	203,537	237,460	33,923
Washington	172,933	172,933	201,755	28,822
West Virginia	100,000	100,000	120,000	20,000
Wisconsin	147,846	147,846	172,487	24,641
Wyoming	100,000	100,000	120,000	20,000
Subtotal	9,671,519	9,671,519	11,360,105	1,688,586
Tribes			250,000	250,000
Guam	100,000	100,000	120,000	20,000
Puerto Rico	128,481	128,481	149,895	21,414
Virgin Islands	100,000	100,000	120,000	20,000
Subtotal	328,481	328,481	639,895	311,414
Total States/Territories	10,000,000	10,000,000	12,000,000	2,000,000
TOTAL RESOURCES	\$10,000,000	\$10,000,000	\$12,000,000	\$2,000,000

OTHER PROGRAMS

Authorizing Legislation -- Titles I, X, XI, XIV and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch.9).

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
Territories -- Adults	\$23,000,000	\$23,000,000	\$23,000,000	\$0
Repatriation	<u>834,000</u>	<u>1,000,000</u>	<u>1,000,000</u>	<u>0</u>
Subtotal, BA	23,834,000	24,000,000	24,000,000	0

Purpose and Method of Operation**Payments to Territories -- Adults (Aged, Blind and Disabled)**

State maintenance assistance programs for the aged, blind and disabled were federalized under Title XVI of the Social Security Act as the Supplemental Security Income program on January 1, 1974. A small residual program, however, remains for the residents of Puerto Rico, Guam, and the Virgin Islands. These grants are subject to spending limitations under Section 1108 of the Social Security Act. The limitations, which were established by P.L. 104 - 193 and most recently amended by P.L. 105-33, are: \$107,255,000 for Puerto Rico, \$4,686,000 for Guam, \$3,554,000 for the Virgin Islands, and \$1,000,000 for American Samoa.

Repatriation

This program provides assistance to U.S. citizens and their dependents returning from foreign countries who have been determined by the Department of State to be destitute, mentally ill or requiring emergency evacuation due to threatened armed conflict, civil strife or natural disasters. The authorizing statute, Section 1113 of the Social Security Act, sets the funding level for the repatriation program. Spending is entirely dependent upon external events, and is affected substantially by the extent of conflict and natural disasters abroad.

The repatriation program traditionally reimburses States directly for assistance provided by them to individual repatriates and for State administrative costs. In January 1997, the program entered into a cooperative agreement with a national, private organization for provision of some of the direct services for the destitute and mentally ill individuals. All individuals receiving assistance are expected to repay the cost of such assistance. These repatriate debts are collected by the Program Support Center, which is the HHS component charged with collecting debts owed by individuals.

Rationale for the Budget Request

Amounts requested for FY 2004 reflect the continued operation of these existing programs.

Resource and Program Data
Payments to Territories – Adults (Aged, Blind, Disabled)

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$23,000,000	\$23,000,000	\$23,000,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$23,000,000	\$23,000,000	\$23,000,000
<u>Program Data:</u>			
Number of Grants	3	3	3
New Starts:			
#			
\$			
Continuations:			
#	3	3	3
\$	\$23,000,000	\$23,000,000	\$23,000,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

Resource and Program Data
Repatriation

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary	\$834,000	\$1,000,000	\$1,000,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$834,000	\$1,000,000	\$1,000,000
<u>Program Data:</u>			
Number of Grants	1	1	1
New Starts:			
#			
\$			
Continuations:			
#	1	1	1
\$	\$834,000	\$1,000,000	\$1,000,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**PRIOR YEAR AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) AND
RELATED PROGRAMS**

Authorizing Legislation -- Title IV-A of the Social Security Act.

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
AFDC benefit payments and Emergency Assistance	\$124,008,000	\$10,000,000	\$0	-\$10,000,000
State/Local Welfare Administration	<u>3,052,000</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total, BA	\$127,060,000	\$10,000,000	\$0	-\$10,000,000

Rationale for the Budget Request

The FY 2004 estimate does not include payments for the AFDC and related programs. States had until August 21, 1998, to submit prior-year claims for expenditures incurred before the AFDC, EA and IV-A child care programs were repealed by PRWORA. The FY 2004 request includes appropriations language to provide authority to pay prior year claims in the event that disputed claims from prior years are not resolved during FY2003.

Resource and Program Data
Aid to Families with Dependent Children (AFDC) Benefit Payments

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$124,008,000	\$10,000,000	
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical			
Program Support			
Total, Resources	\$124,008,000	\$10,000,000	
<u>Program Data:</u>			
Number of Grants	3	1	
New Starts:			
#			
\$			
Continuations:			
#	3	1	
\$	\$124,008,000	\$10,000,000	
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

Resource and Program Data
State and Local Welfare Administration

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$3,052,000		
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical			
Program Support			
Total, Resources	\$3,052,000		
<u>Program Data:</u>			
Number of Grants	1		
New Starts:			
#			
\$			
Continuations:			
#	1		
\$	\$3,052,000		
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Payments to States for Foster Care and Adoption Assistance

<u>FY 2004 Budget</u>	<u>Page</u>
Appropriation Language and Explanation of Language Changes	C-2
Amount Available for Obligation	C-3
Summary of Changes	C-4
Budget Authority by Activity	C-5
Budget Authority by Object	C-6
Significant Items in House, Senate, and Conference Appropriation Committee Reports	C-7
Authorizing Legislation	C-8
Appropriations History Table	C-9
Justification:	
General Statement	C-10
Foster Care	C-12
Adoption Assistance	C-20
Independent Living	C-25

ADMINISTRATION FOR CHILDREN AND FAMILIES
Payments to States for Foster Care and Adoption Assistance

For making payments to States or other non-Federal entities under title IV-E of the Social Security Act, [\$4,801,800,000] \$5,043,200,000. In addition, for carrying out section 477(i), \$60,000,000.

For making payments to States or other non-Federal entities, under title IV-E of the Act, for the first quarter of fiscal year [2004, \$1,745,600,000] 2005, \$1,767,700,000.

For making, after May 31 of the current fiscal year, payments to States or other non-Federal entities under section 474 of title IV-E, for the last 3 months of the current fiscal year for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

*Departments of Labor, Health and Human Services and Education, and Related Agencies
Appropriations Act, 2003, as proposed in the FY 2003 President's Budget*

Note: The President's Budget includes a legislative proposal supporting the creation of a child welfare program option for the Foster Care program which would require an additional \$35.3 million in FY 2004 and an increase in the advance for FY 2005 of \$54.5 million.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Payments to States for Foster Care and Adoption Assistance

Amounts Available for Obligation

	<u>2002 Actual</u>	<u>2003 President's Budget</u>	<u>2004 Estimate</u>
Appropriation Annual (definite)	\$4,885,592,000	\$4,801,800,000	\$5,138,500,000
Permanent	1,735,900,000	1,754,000,000	1,735,400,000
Appropriation lapsing	-552,401,358	-150,800,000	0
Total, obligations	\$6,069,090,642	\$6,405,000,000	\$6,873,900,000

Payments to States for Foster Care and Adoption Assistance

SUMMARY OF CHANGES

FY 2003 President's Budget Request

Total estimated budget authority	\$6,555,800,000
(Obligations)	\$6,405,000,000

FY 2004 Estimate	\$6,873,900,000
(Obligations)	\$6,873,900,000
Net change	+\$318,100,000
(Obligations)	+\$468,900,000

	<u>2003 President's Budget Base</u>	<u>Change from Base</u>
Increases:		
A. <u>Built-in:</u>		
1. Adoption assistance -- Increase in children and payments	\$1,619,800,000	+\$79,900,000
2. Foster care -- Increase in payments	4,736,000,000	+202,900,000
Total Built-in Increases		+\$282,800,000
B. <u>Program:</u>		
1. Foster Care -- Increase for new alternative funding option for foster care		+35,300,000
Total Program increases		+\$35,300,000
Net Change		+\$318,100,000

Payments to States for Foster Care and Adoption Assistance

Budget Authority by Activity

	<u>2002</u> <u>Actual</u>	2003 President's Budget	2004 <u>Estimate</u>
Foster Care	\$5,055,492,000	\$4,736,000,000	\$4,974,200,000
Adoption Assistance.....	1,426,000,000	1,619,800,000	1,699,700,000
Independent Living.....	140,000,000	200,000,000	200,000,000
Total Budget Authority.....	\$6,621,492,000	\$6,555,800,000	\$6,873,900,000
(Total Obligations).....	(6,069,090,642)	(6,405,000,000)	

Payments to States for Foster Care and Adoption Assistance

Budget Authority by Object

	2003 President's Budget	2004 Estimate	Increase or Decrease
Salaries and benefits (11.0, 12.0 & 13.0)	\$210,000	\$215,000	+\$5,000
Travel (21.0)	4000	4000	0
Communications, utilities and misc. (23.0)	40,000	40,000	0
Advisory and assistance Services (25.1)	12,130,000	17,709,000	+5,579,000
Research and development (25.5)	1,600,000	1,600,000	0
Supplies and materials (26.0)	14,000	14,000	0
Equipment (31.0)	2,000	2,000	0
Grants, subsidies and contributions (41.0)	6,391,000,000	6,854,316,000	+463,316,000
Total Obligations	\$6,405,000,000	\$6,873,900,000	+\$468,900,000

ADMINISTRATION FOR CHILDREN AND FAMILIES

Payments to States for Foster Care and Adoption Assistance

SIGNIFICANT ITEMS IN HOUSE, SENATE AND CONFERENCE
APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2003 Congressional requirements for reports and significant items derived from Senate Report 107-216 (Labor, Health and Human Services and Education). These actions discussed below are contingent on inclusion of similar language and funding in the final FY 2003 appropriation and related reports. Additional items may be transmitted at a later date as a result of the final Conference report.

2003 Senate Committee Report LanguageItem

[Child and Family Services Reviews] The Committee continues its interest in the Department's Child and Family Services reviews. These reviews are an effective method for monitoring the progress States are making in assuring the safety, health and permanency for children in child welfare and foster care as required in the Adoption and Safe Families Act. The Committee encourages the Department to make available sufficient resources to ensure full implementation of the new collaborative monitoring system. The Committee understands that the remaining States will be reviewed during fiscal year 2003. The Committee requests that ACF prepare a report on compliance and other implementation issues identified during these reviews and provide it to the Committee not later than 90 days after the last review.

Action Taken or to be Taken

The Administration agrees with the Committee about the value and importance of the reviews and plans to provide the Committee with the information requested. However, due to the time required to fully complete the evaluation and compilation of the information gathered during the reviews, the Administration will not be able to provide the report requested until 180 days after the completion of the final review.

Payments to States for Foster Care and Adoption Assistance

Authorizing Legislation

	<u>2003 Amount Authorized</u>	<u>2003 President's Budget</u>	<u>2004 Amount Authorized</u>	<u>2004 Estimate</u>
1. Foster Care [Section 470 of Title IV-E of the Social Security Act, as amended]	Indefinite	\$4,736,000,000	Indefinite	\$4,974,200,000
2. Independent Living [Sections 470 and 477 of Title IV-E of the Social Security Act, as amended]	\$200,000,000	\$200,000,000	\$200,000,000	\$200,000,000
3. Adoption Assistance [Section 470 of Title IV-E of the Social Security Act, as amended]	Indefinite	\$1,619,800,000	Indefinite	\$1,699,700,000
Total Budget Authority		\$6,555,800,000		\$6,873,900,000
Appropriation against definite authorization		\$200,000,000		\$200,000,000

Payments to States for Foster Care and Adoption Assistance

APPROPRIATIONS HISTORY TABLE

<u>Year</u>	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1995				
Appropriation	3,440,871,000	3,597,371,000	3,597,371,000	3,597,371,000
Supplemental	26,291,000	0	0	0
1996	4,307,842,000	4,307,842,000	4,322,238,000	4,322,238,000
1997	4,445,000,000	4,445,031,000	4,445,031,000	4,445,031,000
1998	4,311,000,000	4,311,000,000	4,311,000,000	4,311,000,000
1999				
Advance ¹	1,157,700,000	1,157,500,000	1,157,500,000	1,157,500,000
Appropriation	3,964,000,000	3,764,900,000	3,964,000,000	3,764,000,000
2000				
Advance	1,355,300,000	1,355,300,000	1,355,300,000	1,355,300,000
Appropriation	4,312,300,000	4,307,300,000	4,312,000,000	4,307,300,000
Supplemental	35,000,000	35,000,000	35,000,000	35,000,000 ²
2001				
Leg. proposal	5,000,000	0	0	0
Advance	1,549,700,000	1,538,000,000	1,538,000,000	1,538,000,000
Appropriation	4,863,100,000	4,863,100,000	4,863,100,000	4,863,100,000
2002				
Advance	1,735,900,000	1,735,900,000	1,735,900,000	1,735,900,000
Appropriation	4,885,000,000	4,885,600,000	4,885,600,000	4,885,600,000
Leg. proposal	60,000,000	0	0	0
Rescission				8,000
2003				
Advance	1,754,000,000	1,754,000,000	1,754,000,000	1,754,000,000
Appropriation	4,801,800,000			
2004				
Advance	1,735,400,000			
Appropriation	5,103,200,000			
Leg. Proposal	35,300,000			
2005				
Advance	1,767,700,000			
Leg. Proposal	54,500,000			

¹ Beginning in the FY 1998 appropriations bill, the Congress began appropriating the first quarter of the next fiscal year for this program in addition to the regular appropriation.

² Reflects \$35 million in supplemental funding for the Independent Living Program.

Payments to States for Foster Care and Adoption Assistance

Justification

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Foster Care.....	\$5,055,500,000	\$4,736,000,000	\$4,974,200,000	+\$238,200,000
Adoption Assistance	1,426,000,000	1,619,800,000	1,699,700,000	+\$79,900,000
Independent Living.....	140,000,000	140,000,000	140,000,000	0
Independent Living Training Vouchers		60,000,000	60,000,000	0
Total, BA.....	\$6,621,500,000	\$6,555,800,000	\$6,873,900,000	+\$318,100,000

General Statement

Child welfare programs are designed to enhance the capacity of families to raise children in a nurturing, safe environment; to protect children who have been or are at risk of being abused or neglected; to provide safe, stable, family-like settings consistent with the needs of each child when remaining at home is not in the best interest of the child; to reunite children with their biological families when appropriate; and to secure adoptive homes or other permanent living arrangements for children whose families are not able to care for them. Ensuring the health and safety of the child is always of primary importance in delivering any child welfare service. Key federal entitlement programs supporting child welfare services include the Foster Care, Adoption Assistance, Independent Living, and Promoting Safe and Stable Families programs. Discretionary programs include Child Welfare Services State grants, Child Welfare Training, Child Abuse and Neglect State grants, the Community-Based Family Resource and Support grants, the Abandoned Infants Assistance program, the Adoption Opportunities program, and the Adoption Incentives program.

Payments to States for Foster Care and Adoption Assistance include those entitlement programs which assist States with the costs of maintaining eligible children in foster care, preparing children for living on their own, and adopting children under special conditions. Administrative and training costs are also supported. Legislation is being proposed to create an alternative

funding option for the Foster Care program. The President's appropriation request is \$6,873,900,000 for this account.

The request also includes \$1,822,200,000 for the first quarter of FY 2005. These funds will ensure the timely awarding of first quarter grants.

The following tables illustrate how the FY 2004 request for new budget authority was derived:

CURRENT LAW

<u>IV-E Program</u>	Appropriated in FY 2003 for the First Quarter of FY 2004	Requirement for Quarters 2, 3, and 4 FY 2004	First Quarter Requirement for FY 2005	Total FY 2004 Estimate
Foster Care	\$1,237,000,000	\$3,737,200,000	\$1,314,600,000	\$4,974,200,000
Adoption Assistance	\$463,400,000	\$1,236,300,000	\$472,600,000	\$1,699,700,000
Independent Living	\$35,000,000	\$165,000,000	\$35,000,000	\$200,000,000
Subtotal, IV-E				
Current Law	\$1,735,400,000	\$5,138,500,000	\$1,822,200,000	\$6,873,900,000

FOSTER CARE

Authorizing legislation -- Section 470 of the Social Security Act, as amended

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$5,055,492,000	\$4,736,000,000	\$4,974,200,000	+\$238,200,000

2004 Authorization....Indefinite (with legislative modifications proposed in the FY 2004 budget).

Purpose and Method of Operation

Consistent with ACF's goal to improve healthy development, safety, and well-being of children and youth and to increase the safety, permanency, and well-being of children and youth, this program provides funds to States for foster care maintenance payments; administrative costs to manage the program, including costs for statewide automated information systems; and training of staff and foster and adopting parents.

The system is an annually appropriated entitlement program with specific eligibility requirements and fixed allowable uses of funds. Federal financial participation in State expenditures for foster care maintenance payments is provided at the Medicaid match rate for medical assistance payments which varies among States from 50 percent to 79 percent. Federal financial participation for State administrative expenditures is made at a 50 percent rate and at a 75 percent rate for the training of State or local agency personnel, foster parents, or staff of state licensed or approved institutions.

The Social Security Act links the title IV-E programs, including Foster Care, to title IV-B programs (the Child Welfare Services State Grant Program and the Promoting Safe and Stable Families Program). The same State agency must administer or supervise the administration of the programs. The goal of the programs is to strengthen families in which children are at risk. Taken together, these programs provide a continuum of services to assist children and their families. The Social Security Act also authorizes the Adoption and Foster Care Analysis Reporting System (AFCARS). This mandatory data collection system collects information from the States on all children in foster care who are the responsibility of State child welfare agencies and all children adopted with the involvement of State child welfare agencies.

To strengthen services provided to these vulnerable children and further the goal of helping States develop a seamless system for child welfare services, ACF is proposing legislation to offer States an alternative financing system to the current entitlement program. Under this alternative system, States could choose to administer their foster care program within a fixed allocation of funds over a five-year period, if this approach would better support their unique child welfare needs.

The alternative program would encompass funding for the existing title IV-E foster care maintenance payments program and the associated administrative costs, including funding for the State Automated Child Welfare Information Systems. States that select this alternative financing structure will be required to apply for the fixed allocation approach soon after enactment of the legislation and must commit to the new funding structure for the full five-year period. Funding for the program will be cost neutral over five years. However, to support State creativity, States will be permitted to receive up-front funding through this option. The proposal includes a maintenance of effort requirement to ensure that States that choose the new option maintain their existing level of investment in the program. State allocations will be derived using historic expenditure rates.

States that choose the fixed allocation option will enjoy far more flexibility than that afforded under the existing IV-E program both in allowable activities and in the population served. States will be able to use the funds for purposes under title IV-E or title IV-B, including foster care maintenance payments, prevention activities, permanency efforts (including subsidized guardianships), case management, administrative activities (including developing and operating State information systems), the training of child welfare staff and other such services related to child welfare activities. The proposal will provide States with the flexibility to develop a child welfare system that supports a continuum of services to families in crisis and children at risk while removing the administrative burden of many of the current federal requirements. States will have the flexibility to try innovative ways to insure the safety, permanency and well-being of children. However, the Department will require States to maintain existing child protections to ensure that States maintain their focus on child safety, permanency and well-being when providing services.

States which elect to use the alternative funding option and which experience emergencies affecting their foster care systems may apply for access to additional funding from the Temporary Assistance for Needy Families (TANF) Contingency Fund. States which choose to apply would be required to meet strict guidelines to ensure only truly needy States receive additional resources.

Two set-asides will be created within this new program. The first set-aside will be \$30 million for Indian tribes or consortia that can demonstrate the capacity to operate a title IV-E program. Allocations for each tribe or consortia that qualifies will be based on the tribe's population of children under age 21. Indian tribes will have similar program requirements as do States, however, the Secretary will have the authority to waive certain State program requirements that are burdensome to Indian tribes but do not affect or compromise child safety. The second set-aside will be an administrative set-aside of 1/3 of one percent in order to facilitate the monitoring and technical assistance necessary to support the success of State child welfare programs.

Funding for Foster Care maintenance payments, administration, and training during the last five fiscal years has been as follows:

1999	\$3,982,700,000
2000	\$4,537,200,000
2001	\$5,063,500,000
2002	\$5,055,500,000
2003	\$4,736,000,000

Rationale for the Budget Request

In FY 2004, federal assistance of \$4,974,200,000 is requested, an increase of \$238,200,000 over the FY 2003 request. Of this amount, \$1,237,000,000 was made available for the first quarter of FY 2004 in the FY 2003 budget. In addition, \$1,314,600,000 is requested for the first quarter of FY 2005 to ensure timely first quarter grant awards. The additional funds reflect up-front funding costs assumed under the new child welfare program option being proposed for States, as well as increases in basic program costs.

The proposed legislation will provide States and Indian tribes with the opportunity to design a flexible child welfare system that supports a continuum of services to families in crisis and children at risk while removing the administrative burden of many of the current federal requirements. The current determination and re-determination for IV-E eligibility is a significant burden to States. Additionally, the cost allocation process for claiming administrative costs under the IV-E system is cumbersome. Both would be eliminated for States that choose the alternative funding structure. The proposed approach will provide significant resources and flexibility for States and tribes to fund prevention, treatment and permanent placement activities. In addition, these funds will support out-of-home care when that option is determined to be in the best interest of the child. The proposal will make the child welfare system more efficient and provide increased flexibility to the States for designing a seamless child welfare system.

Under the proposed funding option, States can receive up-front funding at the outset of the program cycle with funds evenly distributed across each of the five years. As States begin designing their foster care programs under the fixed allocation option it is essential to provide sufficient funds to allow States the time and flexibility to implement innovative, cost efficient programs. States have long raised concerns that the title IV-E foster care program is too restrictive. The funding flexibility and up-front funding provided through the alternative funding option in the first years of the program will allow States to make changes to their child welfare systems and to reorganize their service delivery techniques in new and innovative ways to best serve children and their families.

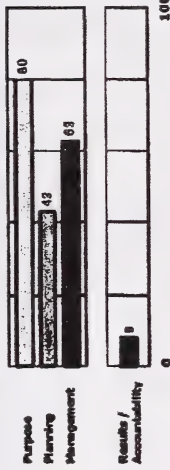
This alternative for States will not affect or change the provisions of the Adoption and Safe Families Act. Permanency for children will continue to be of paramount concern under the foster care program, regardless of the funding mechanism chosen by the States. Similarly, this alternative option for the Foster Care program will not affect or change the Adoption Assistance program, the John H. Chafee Foster Care Independence Program, or title IV-B of the Social Security Act.

The proposed administrative set-aside will allow for the carrying out of critical parts of the child welfare program option, federal monitoring, technical assistance, and child welfare research. The set-aside will also be used to examine the safety, permanence and well-being of children in States that choose the alternative funding option.

A PART assessment was conducted for this program and helped inform the FY 2004 budget policy. A summary of the PART assessment follows on the next page.

Program: Foster Care

Agency: Department of Health and Human Services
Bureau: Administration for Children and Families



☐ Results Achieved
☒ Results Not Demonstrated
☐ Measures Adequate
☒ New Measures Needed

Key Performance Measures

Long-term measure: Performance under development	Year	Target	Actual
Annual Measure: Percentage of children with substantiated reports of maltreatment that have a repeated substantiated report of maltreatment within 6 months	1999	8%	
	2000	9%	
	2001	7%	
	2004	7%	
Annual Measure: Percentage of children with no more than 2 placement settings, for those who had been in care less than 12 months	1999	60%	
	2000	58%	
	2001	72%	
	2002	60%	

Rating: Results Not Demonstrated

Program Type: Block/Formula Grants

Program Summary:

The purpose of the federal foster care program is to prevent maltreatment and abuse of children in troubled families by providing a stable temporary home - a foster care family - until the children can safely return to their homes, or a permanent home is found. Foster Care Maintenance Payments go to foster parents to cover the costs of a child's food, shelter, clothing, supervision, and travel home for visits.

The assessment indicates that the overall purpose of the program is clear and addresses a specific need. However, the program is suboptimal in design because the program financial structure does not provide appropriate incentives for the permanent placement of children. Additional findings include:

1. Program performance goals are non-specific and target measures are unambiguous.
2. There is a lack of independent evaluations, the budget and program goals are not aligned, and the program takes a proactive, systematic process to address strategic planning deficiencies.
3. While program management is generally sound, relatively high erroneous payments indicate that program funds are not always spent for the intended purpose. There is no existing performance measure to reduce erroneous payments.
4. Finally, there has been inadequate progress toward meeting performance goals.

To address these findings, the Administration recommends legislation to introduce an option available to all states to participate in an enhanced foster care system for child welfare that will better meet the needs of the states' foster care population. The change will focus on getting results. States choosing to participate will face fewer administrative burdens and increased funding in the form of flexible grants. This will serve as an incentive to create innovative child welfare plans with a stronger emphasis on prevention and family support, and increased flexibility in services provided and population served. State flexibility will be balanced with accountability to ensure the best outcomes for vulnerable children and their families. Participating states must continue to provide for the safety, permanency, and well-being of children by upholding high standards of performance.

Program Funding Level (in millions of dollars)

2002 Actual	2003 Estimate	2004 Estimate
4,380	4,629	4,857

Resource and Program Data
Foster Care Program

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$4,527,682,074	\$4,655,100,000	\$4,957,616,017
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	8,074,775	10,730,000	\$16,313,983
Program Support ¹	266,865	270,000	270,000
Total, Resources	\$4,536,023,714	\$4,666,100,000 ²	\$4,974,200,000
<u>Program Data:</u>			
Number of Grants	52	52	52
New Starts:			
#	52	52	52
\$	\$4,527,682,074	\$4,655,100,000	\$4,957,616,017
Continuations:			
#			
\$			
Contracts:			
#	7	8	10
\$	\$8,412,224	\$11,000,000	\$16,583,983
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support.

² Assumes lapse of \$69.9 million

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Title IV-E Foster Care (CFDA # 93.658)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$26,760,886	\$27,513,990	\$29,093,372	\$1,579,382
Alaska	9,042,860	9,297,344	9,831,038	533,694
Arizona	37,175,514	38,221,706	40,415,741	2,194,035
Arkansas	27,203,730	27,969,297	29,574,814	1,605,517
California	1,088,647,403	1,119,284,091	1,183,534,191	64,250,100
Colorado	46,103,583	47,401,029	50,121,983	2,720,954
Connecticut	69,374,824	71,327,169	75,421,552	4,094,383
Delaware	9,263,456	9,524,148	10,070,861	546,713
District of Columbia	21,828,710	22,443,013	23,731,306	1,288,293
Florida	134,026,727	137,798,504	145,708,531	7,910,027
Georgia	71,401,052	73,410,419	77,624,386	4,213,967
Hawaii	18,410,017	18,928,111	20,014,639	1,086,528
Idaho	4,376,501	4,499,664	4,757,958	258,294
Illinois	305,506,615	314,104,175	332,134,651	18,030,476
Indiana	37,342,838	38,393,739	40,597,649	2,203,910
Iowa	10,629,385	10,928,517	11,555,845	627,328
Kansas	16,581,834	17,048,480	18,027,111	978,631
Kentucky	54,934,182	56,480,139	59,722,260	3,242,121
Louisiana	54,485,044	56,018,361	59,233,975	3,215,614
Maine	27,675,395	28,454,235	30,087,590	1,633,355
Maryland	154,288,328	158,630,307	167,736,139	9,105,832
Massachusetts	67,467,647	69,366,320	73,348,145	3,981,825
Michigan	152,602,354	156,896,886	165,903,215	9,006,329
Minnesota	97,894,964	100,649,922	106,427,514	5,777,592
Mississippi	17,758,511	18,258,271	19,306,347	1,048,076
Missouri	56,504,939	58,095,100	61,429,924	3,334,824
Montana	5,041,737	5,183,621	5,481,176	297,555
Nebraska	21,682,977	22,293,179	23,572,871	1,279,692
Nevada	22,940,772	23,586,371	24,940,296	1,353,925
New Hampshire	9,659,143	9,930,970	10,501,036	570,066
New Jersey	43,587,491	44,814,129	47,386,588	2,572,459
New Mexico	13,481,921	13,861,329	14,657,009	795,680
New York	534,881,945	549,934,581	581,502,394	31,567,813
North Carolina	62,944,888	64,716,282	68,431,181	3,714,899
North Dakota	13,694,141	14,079,521	14,887,726	808,205

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	206,408,086	212,216,818	224,398,668	12,181,850
Oklahoma	27,515,259	28,289,593	29,913,496	1,623,903
Oregon	32,147,503	33,052,197	34,949,488	1,897,291
Pennsylvania	398,423,564	409,635,991	433,150,265	23,514,274
Rhode Island	12,628,699	12,984,096	13,729,420	745,324
South Carolina	36,969,774	38,010,177	40,192,069	2,181,892
South Dakota	5,418,760	5,571,255	5,891,061	319,806
Tennessee	24,043,159	24,719,781	26,138,767	1,418,986
Texas	145,823,169	149,926,921	158,533,154	8,606,233
Utah	22,033,702	22,653,774	23,954,165	1,300,391
Vermont	12,494,283	12,845,897	13,583,288	737,391
Virginia	85,322,222	87,723,358	92,758,929	5,035,571
Washington	55,825,569	57,396,611	60,691,340	3,294,729
West Virginia	27,567,713	28,343,523	29,970,522	1,626,999
Wisconsin	78,152,315	80,351,676	84,964,091	4,612,415
Wyoming	2,490,768	2,560,863	2,707,864	147,001
Subtotal	4,518,466,859	4,645,625,451	4,912,297,601	266,672,150
Puerto Rico	9,215,215	9,474,549	10,018,416	543,867
Subtotal	9,215,215	9,474,549	10,018,416	543,867
Total States/Territories	4,527,682,074	4,655,100,000	4,922,316,017	267,216,017
Technical Assistance	8,341,640	11,000,000	16,583,983	5,583,983
Child welfare program option additional funds			35,300,000	35,300,000
Subtotal adjustments	8,341,640	11,000,000	51,883,983	40,883,983
TOTAL RESOURCES	\$4,536,023,714	\$4,666,100,000¹	\$4,974,200,000	\$308,100,000

¹ Assumes lapse of \$69.9 million

ADOPTION ASSISTANCE

Authorizing legislation -- Section 470 of the Social Security Act, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$1,426,000,000	\$1,619,800,000	\$1,699,700,000	+\$79,900,000

2004 Authorization....Indefinite.

Purpose and Method of Operation

The Adoption Assistance program, consistent with ACF's goals to improve healthy development, safety, and well-being of children and youth and to increase the safety, permanency, and well-being of children and youth, provides funds to States to subsidize families that adopt children with special needs who cannot be reunited with their families, thus preventing long, inappropriate stays in foster care. To receive adoption assistance benefits, a child must have been determined by the State to be a special needs child, e.g., be older, a member of a minority or sibling group, or have a physical, mental, or emotional disability. Additionally, the child must have been:

- unable to return home, and the State must have been unsuccessful in its efforts to adopt without medical or financial assistance; and
- receiving or eligible to receive Aid to Families with Dependent Children, as in effect on July 16, 1996, or title IV-E Foster Care benefits, or Supplemental Security Income benefits.

Funds also are used for the administrative costs of managing the program and training staff and adoptive parents.

Adoption Assistance is an annually appropriated entitlement program. Federal financial participation in State maintenance expenditures is provided at the Medicaid match rate for medical assistance payments, which varies among States from 50 percent to 79 percent. State adoption subsidy payments made on behalf of individual children also vary from State to State but may not exceed foster family care rates for comparable children. State administrative costs are matched at a 50 percent rate and training for State and local employees and adoptive parents at a 75 percent rate.

The number of children subsidized by this program and the level of federal reimbursement have increased significantly as permanent adoptive homes are found for more children. Over the past five years, the average monthly number of children for whom payments were made has nearly doubled, from just fewer than 147,000 in FY 1997 to an estimated 285,600 in FY 2002.

Funding for Adoption Assistance over the past five years have been as follows:

1999	.....	\$868,800,000
2000	.....	\$1,020,100,000
2001	.....	\$1,197,600,000
2002	.....	\$1,426,000,000
2003	.....	\$1,619,800,000

Rationale for the Budget Request

Title IV-E Adoption Assistance provides federal assistance to States to support the adoption of eligible children with special needs. In FY 2004 an estimated average of 348,700 children per month, an increase of 31,700 children over FY 2003, will have payments made on their behalf, at an estimated cost of \$1,699,700,000, of which \$463,400,000 was appropriated in FY 2003 for the first quarter of FY 2004. This amount includes funds for the costs of administration and training. In addition, the request includes \$472,600,000 for the first quarter of FY 2005 to ensure timely first quarter grant awards. Technical changes will be proposed to align this program with the Foster Care legislation.

The amount requested, together with amounts requested for child welfare discretionary programs, will assist in achieving the performance goal of providing children with permanency and stability in their living situations and minimizing disruption to the continuity of family and other relationships through:

- Increasing the percentage of children who exit the foster care system and are adopted within two years of placement from 23 percent in FY 2001 to 27 percent in FY 2004;
- Making progress toward doubling the number of adoptions in the public foster care system by increasing the number to 60,000 in FY 2004;
- Maintaining the percentage of children who exit the foster care system through reunification within one year of placement at 67 percent in FY 2004; and
- Changing the percentage of children who exit the foster care system through guardianships within two years of placement from 57 percent in FY 2001 to 62 percent in FY 2004.

Resource and Program Data
Adoption Assistance Program

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$1,393,075,328	\$1,538,900,000	\$1,699,700,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$1,393,075,328	\$1,538,900,000 ¹	\$1,699,700,000
<u>Program Data:</u>			
Number of Grants	52	52	52
New Starts:			
#	52	52	52
\$	\$1,393,075,328	\$1,538,900,000	\$1,699,700,000
Continuations:			
#			
\$			
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

¹ Assumes lapse of \$80.9 million.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Title IV-E Adoption Assistance (CFDA # 93.659)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$4,449,789	\$4,915,585	\$5,429,216	\$513,631
Alaska	6,043,216	6,675,810	7,373,366	697,556
Arizona	18,926,328	20,907,504	23,092,134	2,184,630
Arkansas	7,062,625	7,801,929	8,617,154	815,225
California	236,146,069	260,865,442	288,123,330	27,257,888
Colorado	21,577,363	23,836,045	26,326,678	2,490,633
Connecticut	16,315,490	18,023,368	19,906,634	1,883,266
Delaware	1,941,165	2,144,363	2,368,428	224,065
District of Columbia	7,218,613	7,974,245	8,807,476	833,231
Florida	43,932,311	48,531,071	53,602,093	5,071,022
Georgia	35,081,931	38,754,248	42,803,688	4,049,440
Hawaii	7,073,072	7,813,469	8,629,900	816,431
Idaho	2,509,512	2,772,203	3,061,872	289,669
Illinois	74,441,347	82,233,741	90,826,363	8,592,622
Indiana	25,872,098	28,580,346	31,566,712	2,986,366
Iowa	22,448,098	24,797,927	27,389,068	2,591,141
Kansas	9,640,655	10,649,822	11,762,625	1,112,803
Kentucky	13,797,891	15,242,231	16,834,895	1,592,664
Louisiana	6,176,458	6,822,999	7,535,936	712,937
Maine	9,115,929	10,070,169	11,122,403	1,052,234
Maryland	13,099,321	14,470,536	15,982,565	1,512,029
Massachusetts	27,080,201	29,914,911	33,040,726	3,125,815
Michigan	92,035,739	101,669,885	112,293,393	10,623,508
Minnesota	15,860,284	17,520,512	19,351,234	1,830,722
Mississippi	3,635,347	4,015,889	4,435,510	419,621
Missouri	19,228,066	21,240,827	23,460,286	2,219,459
Montana	5,458,913	6,030,343	6,660,455	630,112
Nebraska	5,535,330	6,114,759	6,753,692	638,933
Nevada	4,981,852	5,503,344	6,078,389	575,045
New Hampshire	1,534,208	1,694,806	1,871,897	177,091
New Jersey	16,535,989	18,266,948	20,175,666	1,908,718
New Mexico	10,100,953	11,158,304	12,324,237	1,165,933
New York	200,066,593	221,009,226	244,102,529	23,093,303
North Carolina	18,900,809	20,879,314	23,060,998	2,181,684
North Dakota	2,027,922	2,240,201	2,474,281	234,080

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	134,070,180	148,104,420	163,579,883	15,475,463
Oklahoma	17,583,514	19,424,127	21,453,758	2,029,631
Oregon	19,839,605	21,916,381	24,206,429	2,290,048
Pennsylvania	59,927,897	66,201,048	73,118,410	6,917,362
Rhode Island	5,603,763	6,190,355	6,837,187	646,832
South Carolina	12,714,385	14,045,305	15,512,902	1,467,597
South Dakota	1,493,703	1,650,061	1,822,477	172,416
Tennessee	10,661,046	11,777,026	13,007,610	1,230,584
Texas	43,914,618	48,511,526	53,580,506	5,068,980
Utah	5,770,534	6,374,584	7,040,665	666,081
Vermont	7,021,813	7,756,845	8,567,359	810,514
Virginia	13,167,413	14,545,756	16,065,645	1,519,889
Washington	18,189,169	20,093,180	22,192,721	2,099,541
West Virginia	9,374,935	10,356,287	11,438,418	1,082,131
Wisconsin	27,059,061	29,891,558	33,014,933	3,123,375
Wyoming	657,016	725,791	801,629	75,838
Subtotal	1,392,900,139	1,538,706,572	1,699,486,361	160,779,789
Puerto Rico	175,099	193,428	213,639	20,211
Subtotal	175,099	193,428	213,639	20,211
Total States/Territories	1,393,075,238	1,538,900,000	1,699,700,000	160,800,000
TOTAL RESOURCES	\$1,393,075,238	\$1,538,900,000¹	\$1,699,700,000	\$160,800,000

¹ Assumes lapse of \$80.9 million.

INDEPENDENT LIVING

Authorizing Legislation -- Sections 470 and 477 of the Social Security Act.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$140,000,000	\$200,000,000	\$200,000,000	\$0

2004 Authorization....\$200,000,000¹.

Purpose and Method of Operation

This program originated in 1986 and was permanently authorized as part of Public Law 103-66 in 1993. In FY 1999, the federal Independent Living Program was revised and amended by the enactment of Title I of Public Law 106-169, the John H. Chafee Foster Care Independence Act. The Foster Care Independence Act provides States with more flexibility and additional resources to support child welfare services designed to help youth make the transition from foster care to positive, productive adulthood.

This program provides services to foster children under 18 and former foster youth (aged 18-21) to help them make the transition to independent living by engaging in a variety of services including, but not limited to, educational assistance, career exploration, vocational training, job placement, life skills training, home management, health services, substance abuse prevention, preventive health activities, and room and board.

The current law has improved States' ability to actualize the goals of safety, permanence and well being for youth and young adults in the child welfare system. States have the authority to extend the lower age limit of youth in foster care who are eligible for independent living services, and States may use up to 30 percent of the Chafee Foster Care Independence Program (CFCIP) allotment to provide room and board (age 18-20) and other independent living services to youth (up to age 21) formerly in foster care. Other provisions of the law include: 1) a formula for determining the amount of State allocation based on a State's percent of children in foster care in proportion to the national total of children in foster care, using data from the most recent year available, instead of 1984; and 2) a "hold harmless" provision for the State allotments so that no State will receive less funding under CFCIP than it received in FY 1998 or \$500,000, whichever is greater. States now have the option of providing Medicaid to foster care youth until age 21.

Each State is eligible to receive a portion of the funds appropriated according to the revised formula. In order to be awarded federal funds, States must provide a 20 percent match.

¹ Of this amount, \$140 million is mandatory and \$60 million is discretionary.

In addition, the Administration proposed legislation that was enacted in 2002 to amend sections 474 and 477 of the Social Security Act to provide vouchers of up to \$5,000 for college tuition or vocational training to foster care children from 16 to 21 years of age. (Participants who turn 21 while working toward the completion of a degree or training program may remain eligible for the voucher program until they are 23 years of age.) Funding for these vouchers is authorized at \$60 million, is discretionary in nature and is also distributed based on the foster care ratio, without a minimum guaranteed amount. These vouchers will provide youth an additional resource to prepare for independent living, increasing the prospect that they will be able to secure work and become contributing members of society. In order not to serve as a disincentive to the adoption of older children, the vouchers would also be available to individuals adopted from foster care after reaching age 16.

Funding for Independent Living over the past five years have been:

1999	.....	\$70,000,000
2000	.....	\$140,000,000 ¹
2001	.....	\$140,000,000
2002	.....	\$140,000,000
2003	.....	\$200,000,000 ²

Rationale for the Budget Request

The FY 2004 request of \$200,000,000 is the same as the FY 2003 President's Budget. This will allow continued grants to support both the basic Independent Living Program and the program enacted in 2002 to provide \$5,000 vouchers for youth who "age out" of foster care for college tuition or vocational training.

¹ Includes a supplemental appropriation of \$35,000,000.

² Of this amount, \$140 million is mandatory and \$60 million is discretionary.

Resource and Program Data
Independent Living Program

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$137,900,000	\$197,000,000	\$197,000,000
Discretionary			
Research/Evaluation	1,350,000	1,600,000	1,600,000
Demonstration/Development			
Training/Technical Assistance	300,000	950,000	950,000
Program Support ¹	441,690	450,000	450,000
Total, Resources	\$139,991,690	\$200,000,000	\$200,000,000
<u>Program Data:</u>			
Number of Grants	52	52	52
New Starts:			
#	52	52	52
\$	\$137,900,000	\$197,000,000	\$197,000,000
Continuations:			
#			
\$			
Contracts:			
#	4	4	4
\$	\$1,932,989	\$2,729,958	\$2,729,958
Interagency Agreements:			
#			
\$			

¹Includes funding for information technology support, staffing and associated overhead costs, contract fees, and printing cost.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY/DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Independent Living Program (CFDA #93.674)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$1,336,297	\$2,048,053	\$2,048,053	\$0
Alaska	500,000	744,590	744,590	0
Arizona	1,554,092	2,117,181	2,117,181	0
Arkansas	693,779	1,063,062	1,063,062	0
California	26,987,207	37,727,841	37,727,841	0
Colorado	1,874,643	2,617,587	2,617,587	0
Connecticut	1,498,108	2,577,691	2,577,691	0
Delaware	500,000	608,365	608,365	0
District of Columbia	1,091,992	1,440,960	1,440,960	0
Florida	10,082,821	11,383,114	11,383,114	0
Georgia	2,692,201	4,326,532	4,326,532	0
Hawaii	578,976	915,863	915,863	0
Idaho	500,000	616,427	616,427	0
Illinois	7,925,186	10,111,292	10,111,292	0
Indiana	2,074,958	3,261,408	3,261,408	0
Iowa	1,203,305	1,815,217	1,815,217	0
Kansas	1,573,226	2,212,447	2,212,447	0
Kentucky	1,371,022	2,353,799	2,353,799	0
Louisiana	1,358,131	1,884,253	1,884,253	0
Maine	753,542	1,110,522	1,110,522	0
Maryland	3,098,972	4,311,056	4,311,056	0
Massachusetts	2,755,036	4,175,894	4,175,894	0
Michigan	5,543,378	10,768,870	10,768,870	0
Minnesota	2,149,603	2,847,326	2,847,326	0
Mississippi	769,133	1,050,680	1,050,680	0
Missouri	3,111,964	4,572,780	4,572,780	0
Montana	525,590	711,705	711,705	0
Nebraska	1,470,708	2,138,160	2,138,160	0
Nevada	523,228	695,686	695,686	0
New Hampshire	500,000	634,645	634,645	0
New Jersey	2,297,848	3,783,136	3,783,136	0
New Mexico	500,000	679,562	679,562	0
New York	11,626,283	16,345,347	16,345,347	0
North Carolina	2,576,217	3,483,594	3,483,594	0
North Dakota	500,000	620,197	620,197	0

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	4,847,710	7,553,203	7,553,203	0
Oklahoma	2,018,974	3,124,527	3,124,527	0
Oregon	1,775,194	2,328,624	2,328,624	0
Pennsylvania	5,239,835	7,477,885	7,477,885	0
Rhode Island	591,023	846,391	846,391	0
South Carolina	1,109,998	1,671,115	1,671,115	0
South Dakota	500,000	654,853	654,853	0
Tennessee	2,506,060	3,380,748	3,380,748	0
Texas	4,521,017	6,692,368	6,692,368	0
Utah	500,000	762,819	762,819	0
Vermont	500,000	646,162	646,162	0
Virginia	1,695,116	2,512,690	2,512,690	0
Washington	2,107,084	3,131,062	3,131,062	0
West Virginia	811,652	1,139,411	1,139,411	0
Wisconsin	2,560,154	3,653,822	3,653,822	0
Wyoming	500,000	606,167	606,167	0
Subtotal	135,881,263	193,936,691	193,936,691	0
Puerto Rico	2,018,737	3,063,309	3,063,309	0
Subtotal	2,018,737	3,063,309	3,063,309	0
Total States/Territories	137,900,000	197,000,000	197,000,000	0
Technical Assistance	2,100,000	3,000,000	3,000,000	0
Subtotal Adjustments	2,100,000	3,000,000	3,000,000	0
TOTAL RESOURCES	\$140,000,000	\$200,000,000	\$200,000,000	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Social Services Block Grant

<u>FY 2004 Budget</u>	<u>Page</u>
Appropriation Language	D-2
Amounts Available for Obligation	D-3
Summary of Changes	D-3
Budget Authority by Activity	D-4
Budget Authority by Object	D-4
Authorizing Legislation	D-5
Appropriations History Table	D-6
Justification:	
General Statement	D-7
Social Services Block Grant	D-8

SOCIAL SERVICES BLOCK GRANT

For making grants to States pursuant to section 2002 of the Social Security Act,
\$1,700,000,000.

*Departments of Labor, Health and Human Services and Education, and Related Agencies
Appropriations Act, 2003, as proposed in the FY 2003 President's Budget*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Social Services Block Grant

Amounts Available for Obligation

	<u>2002 Enacted</u>	<u>2003 President's Budget</u>	<u>2004 Estimate</u>
Appropriation:			
Annual.....	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000
Total Obligations.....	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000

SUMMARY OF CHANGES

2003 President's Budget Request	\$1,700,000,000
2004 Estimate.....	<u>\$1,700,000,000</u>
Net Change.....	\$0

Social Services Block Grant

Budget Authority by Activity

	<u>2002</u> <u>Enacted</u>	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>
Social Services Block Grant.....	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000
Total, Budget Authority....	1,700,000,000	1,700,000,000	1,700,000,000
Obligations.....	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000

Budget Authority by Object

	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>	<u>Increase</u> <u>or</u> <u>Decrease</u>
Grants, subsidies and contributions.....	\$1,700,000,000	\$1,700,000,000	\$0
Total, Budget Authority	\$1,700,000,000	\$1,700,000,000	\$0

Social Services Block Grant

Authorizing Legislation

	2003 Amount <u>Authorized</u>	2003 President's <u>Budget</u>	2004 Amount <u>Authorized</u>	2004 Budget <u>Request</u>
Social Services Block Grant (Section 2003 of the Social Security Act, as amended.)	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000

Social Services Block Grant

APPROPRIATIONS HISTORY TABLE

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1995	2,800,000,000	2,800,000,000	2,800,000,000	2,800,000,000
1996	2,800,000,000	2,800,000,000	2,520,000,000	2,381,000,000
1997	2,800,000,000	2,480,000,000	2,240,000,000	2,500,000,000
1998	2,380,000,000	2,245,000,000	2,245,000,000	2,299,000,000
1999	1,909,000,000	2,299,000,000	1,909,000,000	1,909,000,000
2000	2,380,000,000	1,909,000,000	1,050,000,000	1,775,000,000
2001	1,775,000,000	1,700,000,000	600,000,000	1,725,000,000
2002	1,700,000,000	1,700,000,000	1,700,000,000	1,700,000,000
2003	1,700,000,000			
2004	1,700,000,000			

Social Services Block Grant

Justification

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$1,700,000,000	\$1,700,000,000	\$1,700,000,000	\$0

General Statement

The Social Services Block Grant (SSBG) is designed to reduce or eliminate dependency; achieve or maintain self-sufficiency for families; help prevent neglect, abuse or exploitation of children and adults; prevent or reduce inappropriate institutional care; and secure admission or referral for institutional care when other forms of care are not appropriate. The Social Services Block Grant serves low-income children and families, the disabled, and elderly with well-documented need.

Since enactment in 1975, Federal funding under Title XX has represented the Federal Government's partnership with States to ensure the availability of social services for vulnerable families and children and acts as the glue that holds the human services delivery system together. The Social Services Block Grant provides State and local flexibility in managing Federal funds and enables States to target social services to those populations that might not otherwise be eligible for services needed to remain self-sufficient and economically independent.

Services directed toward the program's goals include, but are not limited to: child care services; protective services for children and adults; services for children and adults in foster care; services related to the management and maintenance of home day care services; employment services; information, referral, and counseling services; the preparation and delivery of meals; health support services; and appropriate combinations of services designed to meet the needs of children, the aged, the mentally impaired, the blind, the emotionally disturbed, the physically handicapped, and alcohol and drug addicted individuals.

Activities supported with Social Services Block Grant funds vary from State to State, with each of the 50 States, the District of Columbia, and jurisdictions designing social services programs best suited to meet the specific needs of their residents.

The President's appropriation request of \$1,700,000,000 for this account represents current law requirements. No proposed law amounts are included.

SOCIAL SERVICES BLOCK GRANT

Authorizing Legislation -- Section 2003 of Title XX of the Social Security Act, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$1,700,000,000	\$1,700,000,000	\$1,700,000,000	\$0

2003 Authorization....\$1,700,000,000.

Purpose and Method of Operation

The Social Services Block Grant is an appropriated entitlement program that serves low-income children and families, the disabled and the elderly. Social Services Block Grant funds are distributed to the 50 United States and the District of Columbia, based on each State's relative population as compared to all other States. Distributions are made to Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Commonwealth of the Northern Marianas based on the same ratio allotted to them in 1981 as compared to the total 1981 appropriation. There are no matching requirements.

This program encourages each State, as far as practicable under the conditions in the State, to furnish a variety of social services best suited to the needs of individuals residing within the State.

Funding for the Social Services Block Grant program during the last five years has been as follows:

1999.....	\$1,909,000,000
2000.....	\$1,775,000,000
2001.....	\$1,725,000,000
2002.....	\$1,700,000,000
2003.....	\$1,700,000,000

Rationale for the Budget Request

The FY 2004 request for the Social Services Block Grant is \$1,700,000,000, the same as the FY 2003 President's Budget. The SSBG program provides funding to States for a broad array of services for a variety of populations. SSBG funds are used to prevent, reduce or eliminate dependency; prevent neglect, abuse or exploitation of children and adults; prevent or reduce inappropriate institutional care; and provide admission or referral for institutional care when other forms of care are inappropriate.

Resource and Program Data
Social Services Block Grant

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000
<u>Program Data:</u>			
Number of Grants	57	57	57
New Starts:			
#	57	57	57
\$	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000
Continuations:			
#			
\$			
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Social Services Block Grant (CFDA #93.667)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$26,713,831	\$26,499,688	\$26,499,688	\$0
Alaska	3,765,995	3,768,615	3,768,615	0
Arizona	30,819,824	31,503,450	31,503,450	0
Arkansas	16,059,175	15,979,807	15,979,807	0
California	203,467,765	204,793,075	204,793,075	0
Colorado	25,837,773	26,222,829	26,222,829	0
Connecticut	20,457,307	20,330,680	20,330,680	0
Delaware	4,707,103	4,725,905	4,725,905	0
District of Columbia	3,436,371	3,394,242	3,394,242	0
Florida	96,006,510	97,327,036	97,327,036	0
Georgia	49,176,210	49,765,551	49,765,551	0
Hawaii	7,277,730	7,267,827	7,267,827	0
Idaho	7,772,805	7,841,276	7,841,276	0
Illinois	74,602,977	74,092,901	74,092,901	0
Indiana	36,525,612	36,296,128	36,296,128	0
Iowa	17,578,495	17,351,513	17,351,513	0
Kansas	16,149,388	15,994,949	15,994,949	0
Kentucky	24,278,999	24,132,477	24,132,477	0
Louisiana	26,845,241	26,506,063	26,506,063	0
Maine	7,658,492	7,637,463	7,637,463	0
Maryland	31,816,113	31,906,048	31,906,048	0
Massachusetts	38,139,171	37,866,507	37,866,507	0
Michigan	59,700,460	59,303,859	59,303,859	0
Minnesota	29,551,423	29,514,725	29,514,725	0
Mississippi	17,087,926	16,964,794	16,964,794	0
Missouri	33,610,560	33,417,022	33,417,022	0
Montana	5,419,506	5,368,567	5,368,567	0
Nebraska	10,279,596	10,169,483	10,169,483	0
Nevada	12,003,575	12,501,311	12,501,311	0
New Hampshire	7,423,395	7,474,293	7,474,293	0
New Jersey	50,545,193	50,362,197	50,362,197	0
New Mexico	10,927,051	10,857,512	10,857,512	0
New York	113,992,011	112,848,436	112,848,436	0
North Carolina	48,352,407	48,592,350	48,592,350	0
North Dakota	3,857,710	3,765,980	3,765,980	0

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	68,198,572	67,511,483	67,511,483	0
Oklahoma	20,728,157	20,538,571	20,538,571	0
Oregon	20,552,422	20,614,372	20,614,372	0
Pennsylvania	73,772,572	72,934,516	72,934,516	0
Rhode Island	6,297,276	6,285,576	6,285,576	0
South Carolina	24,100,248	24,117,370	24,117,370	0
South Dakota	4,534,365	4,491,054	4,491,054	0
Tennessee	34,175,653	34,071,828	34,071,828	0
Texas	125,257,360	126,581,825	126,581,825	0
Utah	13,414,697	13,473,097	13,473,097	0
Vermont	3,657,238	3,639,202	3,639,202	0
Virginia	42,520,802	42,665,216	42,665,216	0
Washington	35,406,120	35,543,630	35,543,630	0
West Virginia	10,862,764	10,695,879	10,695,879	0
Wisconsin	32,219,718	32,064,832	32,064,832	0
Wyoming	2,966,160	2,934,814	2,934,814	0
Subtotal	1,690,507,824	1,690,507,824	1,690,507,824	0
American Samoa	54,246	54,246	54,246	0
Guam	293,103	293,103	293,103	0
Northern Mariana Islands	58,621	58,621	58,621	0
Puerto Rico	8,793,103	8,793,103	8,793,103	0
Virgin Islands	293,103	293,103	293,103	0
Subtotal	9,492,176	9,492,176	9,492,176	0
Total States/Territories	1,700,000,000	1,700,000,000	1,700,000,000	0
TOTAL RESOURCES	\$1,700,000,000	\$1,700,000,000	\$1,700,000,000	\$0

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Promoting Safe and Stable Families

<u>FY 2004 Budget</u>	<u>Page</u>
Appropriation Language and Explanation of Language Change	E-2
Amounts Available for Obligation	E-3
Summary of Changes.....	E-4
Budget Authority by Activity	E-5
Budget Authority by Object	E-5
Authorizing Legislation	E-6
Appropriations History Table	E-7
Justification:	
General Statement.....	E-8
Promoting Safe and Stable Families.....	E-10
Mentoring Children of Prisoners	E-15

ADMINISTRATION FOR CHILDREN AND FAMILIES
Promoting Safe and Stable Families

For carrying out section 436 of the Social Security Act, \$305,000,000; for section 437, [\$200,000,000] \$199,978,000; and for section 439, [\$25,000,000] \$50,000,000.

*Departments of Labor, Healih and Human Services and Education, and Related Agencies
Appropriations Act, 2003, as proposed in the FY 2003 President's Budget*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Promoting Safe and Stable Families

Amounts Available for Obligation

	2002 <u>Actual</u>	2003 President's <u>Budget</u>	2004 <u>Estimate</u>
Appropriation:			
Annual ¹	\$374,986,000	\$530,000,000	\$554,978,000
Unobligated balance, lapsing	-1,304	0	0
Total Obligations	\$374,984,696	\$530,000,000	\$554,978,000

¹ Funds are a combination of \$305 million in mandatory funds with the remainder in discretionary funds.

Promoting Safe and Stable Families

SUMMARY OF CHANGES

FY 2003 President's Budget Request

Total estimated budget authority.....	\$530,000,000
---------------------------------------	---------------

FY 2004 Estimate.....	\$554,978,000
-----------------------	---------------

Net change.....	+\$24,978,000
-----------------	---------------

2003 President's

Budget BaseChange from Base

Increases:

Program:

Increase for Mentoring Children of Prisoners	\$25,000,000	+\$25,000,000
--	--------------	---------------

Total Program increases.....		+\$25,000,000
------------------------------	--	---------------

Decreases:

Program:

Reduction in level of information technology support.....	\$200,000,000	-\$22,000
---	---------------	-----------

Total Program decreases		-\$22,000
-------------------------------	--	-----------

Net Change.....		+\$24,978,000
-----------------	--	---------------

Promoting Safe and Stable Families

Budget Authority by Activity

	<u>2002</u> <u>Actual</u>	<u>2003</u> <u>President's Budget</u>	<u>2004</u> <u>Estimate</u>
Promoting Safe and Stable Families	\$374,984,696	\$505,000,000	\$504,978,000
Mentoring Children of Prisoners	0	25,000,000	50,000,000
Total Obligations	\$374,984,696	\$530,000,000	\$554,978,000

Budget Authority by Object

	<u>2003</u> <u>Appropriation</u>	<u>2004</u> <u>Estimate</u>	<u>Increase</u> <u>Or</u> <u>Decrease</u>
Salaries and benefits	\$56,360	\$97,632	+\$41,272
Travel and transportation of things.....	1,500	3,000	+1,500
Advisory and assistance services.....	3,922,421	\$4,576,050	+\$653,629
Purchases of goods and services from government accounts.....	2,357,640	2,626,368	+268,728
Supplies and materials	2,000	3,000	+1,000
Grants, subsidies and contributions	523,660,079	547,671,950	+24,011,871
Total, Budget Authority.....	\$530,000,000	\$554,978,000	+\$24,978,000

Promoting Safe and Stable Families

Authorizing Legislation

	<u>2003 Amount Authorized</u>	<u>2003 President's Budget</u>	<u>2004 Amount Authorized</u>	<u>2004 Estimate</u>
Promoting Safe and Stable Families - Sections 430-438 of the Social Security Act, as amended.	\$505,000,000	\$505,000,000	\$505,000,000	\$504,978,000
Mentoring Children of Prisoners - Section 439 of the Social Security Act, as amended.	\$67,000,000	\$67,000,000	Such sums	\$50,000,000

Promoting Safe and Stable Families

APPROPRIATIONS HISTORY TABLE

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1995	150,000,000	150,000,000	150,000,000	150,000,000
1996	225,000,000	225,000,000	225,000,000	225,000,000
1997	240,000,000	240,000,000	240,000,000	240,000,000
1998	255,000,000	255,000,000	255,000,000	255,000,000
1999	275,000,000	275,000,000	275,000,000	275,000,000
Rescission				-44,000
2000	295,000,000	295,000,000	295,000,000	295,000,000
2001	305,000,000	305,000,000	305,000,000	305,000,000
2002	572,000,000	375,000,000	375,000,000	375,000,000
Rescission				-14,000
2003	530,000,000			
2004	554,978,000			

Promoting Safe and Stable Families

Justification

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$374,986,000	\$530,000,000	\$554,978,000	+\$24,978,000

General Statement

The Promoting Safe and Stable Families program is a combination of a capped entitlement program and a discretionary grant program. Its purpose is to enable each State to operate a coordinated program of family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services.

- Family preservation services are services designed to help families alleviate crises; maintain the safety of children in their own homes; support families who are preparing to reunify or adopt, and assist families to obtain services and other support necessary to address their multiple needs in a culturally sensitive manner. The definition was amended in the recent reauthorization to allow States to support infant safe haven programs.
- Family support services are primarily community-based preventive activities designed to promote parental competencies and behaviors that will increase the ability of families to successfully nurture their children; enable families to use other resources and opportunities available in the community; create supportive networks to enhance child-rearing abilities of parents and help compensate for the increased social isolation and vulnerability of families; and strengthen parental relationships and promote healthy marriages.
- Time-limited reunification services are provided to a child that is removed from home and placed in a foster care setting and to the parents or primary caregiver. These services are available only during a child's first 15 months in foster care in order to facilitate the safe and timely reunification of the family.
- Adoption promotion and support services are designed to encourage more adoptions out of foster care when adoptions promote the best interests of the children. They include pre- and post-adoption services designed to expedite the adoption process and support adoptive families.

Legislation was enacted in November, 2002 to reauthorize this program through FY 2006 and increase the authorization to \$505,000,000 for each year. The new law authorized mandatory funding of \$305 million for FY 2002 through FY 2006 with the existing set-aside amounts. The law also authorized additional discretionary funding of \$200 million for FY 2002 through 2006.

From any discretionary funding, the law provides a 3.3 percent set-aside for evaluation, research and technical assistance, a 3.3 percent set-aside for State Court Improvements and a 2 percent set-aside for grants to tribes. In addition, the new law includes a discretionary initiative to provide competitive grants to State and local governments, Indian tribes and consortia and faith-based and community-based organizations to mentor children of prisoners and those recently released from prison. A grant under the mentoring program is available to pay up to 75 percent of the first two fiscal years for which the grant is awarded and up to 50 percent for subsequent fiscal years.

PROMOTING SAFE AND STABLE FAMILIES

Authorizing Legislation – Sections 436 and 437, Title IV-B, Subpart 2 of the Social Security Act as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$374,986,000	\$505,000,000	\$504,978,000	-\$22,000

2004 Authorization....\$505,000,000 (\$305,000,000 in mandatory funding and \$200,000,000 in discretionary funding).

Purpose and Method of Operation

The Promoting Safe and Stable Families program provides grants to States to develop, establish and expand coordinated programs of four types of community-based services: (1) family preservation services, (2) time-limited family reunification services, (3) community-based family support services, and (4) adoption promotion and support services. States are required to use a portion of these funds for each group of services.

Current law provides that one percent of the mandatory amounts and two percent of discretionary funds appropriated are reserved for allotment to tribal organizations or Indian tribes that have submitted a plan and whose allotment is greater than \$10,000. Tribal allotments are based on the number of children in the tribe relative to the number of children in all tribes with approved plans. The allotment to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands and American Samoa is determined by a formula. From the mandatory funds, \$10 million is set aside for State court improvement programs, and \$6 million is set aside for evaluation, research and training. An additional 3.3 percent of any discretionary funds are to be used for each of the above activities. The remaining funds are distributed to States based on the State's share of children in all States receiving food stamp benefits. States are entitled to payments equal to their allotments, for use in paying not more than 75 percent of the costs of activities under the approved State plan. The remaining 25 percent of costs must be paid with funds from non-federal sources.

States carry out a comprehensive planning process, consulting with a broad range of public and private agencies providing services to families, as well as with parents and families themselves, to ensure that services are coordinated and that funds are spent in a manner responsive to the needs of families.

Funding for the Promoting Safe and Stable Families Program (formerly Family Preservation and Support Program) during the last five years has been as follows:

1999.....	\$275,000,000
2000.....	\$295,000,000
2001.....	\$305,000,000
2002.....	\$374,986,000 ¹
2003.....	\$505,000,000 ²

Rationale for the Budget Request

The FY 2004 request for the Promoting Safe and Stable Families program is \$504,978,000, \$22,000 less than the FY 2003 request. The Administration is committed to helping families in crisis and to protecting children from abuse and neglect. The federal-State child welfare system needs to sustain its investment in supporting and preserving families. The current child welfare system has three primary goals: to ensure children's safety; to create permanency in children's living arrangements; and to promote the well-being of children and families.

¹ Funding is a combination of \$305 million in mandatory funding and \$70 million in discretionary funding.

² Funding is a combination of \$305 million in mandatory funding and \$200 million in discretionary funding.

Resource and Program Data
Promoting Safe and Stable Families

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$356,674,696	\$475,800,000	\$475,779,452
Discretionary	10,000,000	16,600,000	16,599,274
Research/Evaluation	504,652	2,250,000	2,250,000
Demonstration/Development	1,049,868	1,049,177	1,050,000
Training/Technical Assistance	6,299,830	8,600,000	8,617,000
Program Support ¹	455,650	700,823	682,274
Total, Resources	\$374,984,696	\$505,000,000	\$504,978,000
<u>Program Data:</u>			
Number of Grants	56	56	56
New Starts:			
#			
\$			
Continuations:			
#	56	56	56
\$	\$370,191,383	\$499,285,079	\$498,921,950
Contracts:			
#	11	14	14
\$	\$2,688,313	\$3,609,921	\$3,951,050
Interagency Agreements:			
#	5	5	5
\$	\$2,105,000	\$2,105,000	\$2,105,000

¹ Includes funding for information technology support, contract fees and support for Departmental evaluation activities. FY 2004 includes a reduction in information technology support.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

FY 2004 MANDATORY/DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Promoting Safe and Stable Families (CFDA # 93.556)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$7,223,812	\$10,112,024	\$10,111,587	-\$437
Alaska	792,286	999,151	999,108	-43
Arizona	6,346,894	7,626,586	7,626,257	-329
Arkansas	4,412,657	5,963,304	5,963,046	-258
California	55,883,291	67,623,587	67,620,664	-2,923
Colorado	3,366,643	4,018,984	4,018,810	-174
Connecticut	3,417,595	4,295,203	4,295,018	-185
Delaware	813,972	934,971	934,931	-40
District of Columbia	1,575,506	2,070,118	2,070,029	-89
Florida	17,701,135	21,120,278	21,119,366	-912
Georgia	12,352,474	15,695,275	15,694,597	-678
Hawaii	2,184,128	2,817,704	2,817,582	-122
Idaho	1,067,760	1,467,125	1,467,062	-63
Illinois	16,476,219	20,177,255	20,176,384	-871
Indiana	5,562,410	7,507,111	7,506,787	-324
Iowa	2,382,460	2,955,205	2,955,077	-128
Kansas	2,174,220	2,593,227	2,593,115	-112
Kentucky	6,409,881	8,363,654	8,363,293	-361
Louisiana	10,130,810	13,380,172	13,379,594	-578
Maine	1,587,519	1,894,836	1,894,754	-82
Maryland	5,827,063	6,669,187	6,668,899	-288
Massachusetts	5,593,489	6,818,406	6,818,112	-294
Michigan	13,731,216	17,002,407	17,001,673	-734
Minnesota	3,801,649	4,911,755	4,911,543	-212
Mississippi	6,024,915	7,521,007	7,520,682	-325
Missouri	7,571,740	9,696,704	9,696,285	-419
Montana	1,065,149	1,386,792	1,386,732	-60
Nebraska	1,679,725	2,085,839	2,085,749	-90
Nevada	1,294,455	1,589,321	1,589,252	-69
New Hampshire	721,274	926,518	926,478	-40
New Jersey	7,727,122	9,149,934	9,149,539	-395
New Mexico	3,483,414	4,448,232	4,448,040	-192
New York	0	34,597,673	34,596,179	-1,494
North Carolina	8,607,159	12,096,623	12,096,101	-522
North Dakota	600,246	752,309	752,277	-32

Administration for Children and Families
Justification of Estimates for Appropriations Committees

Page E-13
Promoting Safe and Stable Families

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Approp.	Difference +/- 2003
Ohio	12,224,628	15,115,783	15,115,130	-653
Oklahoma	5,024,273	6,417,126	6,416,849	-277
Oregon	3,692,435	4,918,335	4,918,123	-212
Pennsylvania	15,044,630	18,735,616	18,734,807	-809
Rhode Island	1,504,529	2,000,591	2,000,505	-86
South Carolina	6,022,201	7,685,339	7,685,007	-332
South Dakota	836,500	1,130,520	1,130,471	-49
Tennessee	8,775,755	11,356,176	11,355,686	-490
Texas	34,112,074	39,683,910	39,682,196	-1,714
Utah	1,886,385	2,359,224	2,359,122	-102
Vermont	688,968	902,169	902,130	-39
Virginia	7,107,738	8,397,017	8,396,654	-363
Washington	6,290,048	7,460,125	7,459,803	-322
West Virginia	3,748,510	4,772,782	4,772,576	-206
Wisconsin	3,935,636	4,946,991	4,946,777	-214
Wyoming	468,447	607,428	607,402	-26
Subtotal	340,953,045	457,757,609	457,737,840	-19,769
Tribes	4,450,000	7,050,000	7,049,696	-304
American Samoa	221,474	250,125	250,114	-11
Guam	409,423	482,787	482,766	-21
Northern Mariana Islands	160,845	175,073	175,065	-8
Puerto Rico	7,860,670	9,706,692	9,706,273	-419
Virgin Islands	324,543	377,714	377,698	-16
Subtotal	13,426,955	18,042,391	18,041,612	-779
Total States/Territories	354,380,000	475,800,000	475,779,452	-20,548
Technical Assistance	8,294,696	12,600,000	12,599,274	-726
State Courts	12,310,000	16,600,000	16,599,274	-726
Subtotal Adjustments	20,604,696	29,200,000	29,198,548	-1,452
TOTAL RESOURCES	\$374,984,696	\$505,000,000	\$504,978,000¹	\$0

¹ A small reduction in the level of information technology support was taken in FY 2004 in a variety of discretionary accounts, including Promoting Safe and Stable Families. Because the distribution of funds in Promoting Safe and Stable Families is driven by formula, it was not possible to limit the impact to solely program support funding.

MENTORING CHILDREN OF PRISONERS

Authorizing Legislation – Section 439, Title IV-B, Subpart 2 of the Social Security Act, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$0	\$25,000,000	\$50,000,000	+\$25,000,000

2004 Authorization....\$50,000,000.

Purpose and Method of Operation

Legislation was enacted in 2001 to amend Title IV-B subpart 2 of the Social Security Act to create a discretionary program to provide competitive grants to State and local governments, Indian tribes and consortia, and faith and community-based organizations to mentor children of prisoners and those recently released from prison. Applicants can apply for grants up to \$5 million. Grantees are required to become gradually more self-sufficient through public-private partnerships. A grant for a program shall be available to pay up to 75 percent of program cost in the first two fiscal years of funding and up to 50 percent in the subsequent fiscal years.

Funding for Mentoring Children of Prisoners has been as follows:

2003..... \$25,000,000

Rationale for the Budget Request

The FY 2004 request for the Mentoring Children of Prisoners program is \$50,000,000, an increase of \$25 million from the FY 2003 President's Budget. As a result of this funding increase, the number of grants awarded will be doubled in FY 2004.

This program helps children through the time parents are imprisoned, including efforts to keep children connected to a parent in prison, and increase the chances that the family can come together successfully when the parent is released. The arrest and incarceration of a parent often results in traumatic separations for children, followed frequently by erratic shifts from one caregiver to another. As a group, these children are less likely than their peers to succeed in school and more likely to succumb to substance abuse, gangs, early childbearing, and delinquency. Children of incarcerated mothers are particularly vulnerable, as these children typically come from households where the mother was the sole provider, making placement in foster care more likely when the mother is in prison. The limited data available indicates that placements in foster care as a result of a parent's incarceration increased from 2.5 percent of the placements in 1997 to 5.9 percent (roughly 30,000 children) in 1999.

Resource and Program Data
Mentoring Children of Prisoners

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development		\$24,375,000	\$48,750,000
Training/Technical Assistance		312,500	625,000
Program Support ¹		312,500	625,000
Total, Resources		\$25,000,000	\$50,000,000
Program Data:			
Number of Grants		10	20
New Starts:			
#		10	10
\$		\$24,375,000	\$24,375,000
Continuations:			
#			10
\$			\$24,375,000
Contracts:			
#		3	4
\$		\$625,000	\$1,250,000
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support, grant review cost, and staff and associated overhead costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Low Income Home Energy Assistance Program

FY 2004 Budget	Page
Appropriation Language	F-2
Amounts Available for Obligation.....	F-3
Summary of Changes	F-4
Budget Authority by Activity	F-5
Budget Authority by Object.....	F-5
Significant Items in House, Senate, and Conference Appropriations Committee Reports ...	F-6
Authorizing Legislation	F-7
Appropriations History Table	F-8
Justification:	
General Statement.....	F-11
LIHEAP State Grant Program	F-13
LIHEAP Contingency Fund.....	F-17

ADMINISTRATION FOR CHILDREN AND FAMILIES

Low Income Home Energy Assistance Program

For making payments under title XXVI of the Omnibus Budget Reconciliation Act of 1981, \$1,700,000,000.

For making payments under title XXVI of the Omnibus Reconciliation Act of 1981, \$300,000,000: *Provided*, That these funds are for the unanticipated home energy assistance needs of one or more States, as authorized by section 2604(e) of the Act [*Provided further*, That these funds are hereby designated by Congress to be emergency requirements pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985: *Provided further*, That these funds shall be made available only after submission to Congress of an official budget request by the President that includes designation of the entire amount of the request as an emergency requirement as defined in the Balanced Budget and Emergency Deficit Control Act of 1985], and notwithstanding the designation requirement of section 2602(e).

Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act, 2003, as proposed in the FY 2003 President's Budget

Explanation of Language Change

Language is deleted to reflect administration-wide decision to remove BEA emergency designation.

ADMINISTRATION FOR CHILDREN AND FAMILIES
Low Income Home Energy Assistance Program

Amounts Available for Obligation

	<u>2002 Actual</u>	<u>2003 President's Budget</u>	<u>2004 Estimate</u>
Regular Appropriation.....	\$1,700,000,000	\$1,400,000,000	\$1,700,000,000
Contingency Fund.....	[300,000,000]	[300,000,000]	[300,000,000]
Contingency Funds Released.....	100,000,000	200,000,000	NA
Contingency Funds Available from Prior Years..	\$300,000,000 ¹	\$100,000,000 ¹	\$100,000,000 ¹

¹ \$300,000,000 was made available in a supplemental in FY 2001, to remain available until expended. \$200M was released in January, 2003 due to higher than normal energy prices, especially home heating oil.

Low Income Home Energy Assistance Program

SUMMARY OF CHANGES

Regular Program

2003 President's Budget Request.....	\$1,400,000,000
2004 Estimate.....	<u>\$1,700,000,000</u>
Net change.....	<u>+\$300,000,000</u>

Contingency Funds

2003 President's Budget Request.....	\$300,000,000
2004 Request.....	<u>\$300,000,000</u>
Net Change.....	<u>-0-</u>

2003 President's

Budget BaseChange from BaseIncreases:

Program.....	\$1,400,000,000	<u>+\$300,000,000</u>
Total Increases.....		<u>+\$300,000,000</u>

Low Income Home Energy Assistance Program

Budget Authority by Activity

	2002 <u>Actual</u>	2003 President's <u>Budget</u>	2004 <u>Estimate</u>
Program Funds	\$1,672,200,000	\$1,372,200,000	\$1,672,200,000
Leveraging Incentive Funds	27,500,000	27,500,000	27,500,000
Training and Technical Assistance	300,000	300,000	300,000
Contingency Funds	300,000,000	300,000,000	300,000,000
Contingency Funds Released	[100,000,000]	[200,000,000]	NA
Contingency Funds Available from Prior Years	[300,000,000] ¹	[100,000,000] ¹	[100,000,000] ¹
Total, Adjusted Budget Authority	\$2,000,000,000	\$1,700,000,000	\$2,000,000,000

Budget Authority by Object

	2003 President's <u>Budget</u>	2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Travel.....	\$12,000	\$12,000	\$0
Training and technical assistance	288,000	288,000	0
Grants, subsidies and contributions...	1,699,700,000	1,999,700,000	0
Total, Budget Authority.....	\$1,700,000,000	\$2,000,000,000	\$0

¹ Three hundred million dollars (\$300,000,000) was made available in a supplemental in FY 2001 to remain available until expended. \$200 million of that amount was released in January 2003 due to higher than normal energy prices, especially home heating oil.

Low Income Home Energy Assistance Program

SIGNIFICANT ITEMS IN HOUSE, SENATE AND CONFERENCE
APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2003 Congressional requirements for reports and significant items derived from Senate Report 107-216 (Labor, Health and Human Services and Education). These actions discussed below are contingent on inclusion of similar language and funding in the final FY 2003 appropriation and related reports. Additional items may be transmitted at a later date as a result of the final Conference report.

2003 Senate Committee Report LanguageItem

[Contingency Funding] The Committee is disappointed by the unwillingness of the administration to release any or all of the \$600,000,000 in contingency funding currently available. The Committee notes that in both the Statement of the Managers accompanying the Supplemental Appropriations Act, 2001 (Public Law 107-20) and the Statement of the Managers accompanying the Department of Health and Human Services Appropriations Act, 2002 (Public Law 107-116), the conferees encouraged the administration to release contingency funds provided by these Acts due to the pressing additional energy assistance needs of millions of eligible families. The Committee again notes that the authorizing statute states that the contingency fund was authorized to meet the additional home energy assistance needs of one or more States arising from a natural disaster or other emergency, as defined in section 2603(1)(A-G), which includes six other factors not related to weather or natural disasters. The Committee is aware of data that has been reported over the past 12 months that show the definition of emergency has been met in many States. The Committee directs the Department to provide a report within 60 days after the enactment of this bill identifying the sources of data used for considering release of contingency funds for each of the parts of the emergency definition. The Committee encourages the Department to work with appropriate agencies and associations to make sure data is available to administer this program, and in particular, make decisions about release of contingency funding.

Action Taken or to be Taken

The Department will provide the requested report within 60 days after the enactment of the bill. The Administration assesses the need for a LIHEAP emergency release primarily based on weather conditions and energy costs. Therefore, the main sources of data used for considering release of contingency funds are: (a) weather data (Heating/Cooling Degree Days) supplied by the National Weather Service and (b) home energy fuel price data supplied by the Energy Information Administration in the Department of Energy. The report will identify any additional sources of data, if any, used for each of the parts of the emergency definition.

Low Income Home Energy Assistance Program

Authorizing Legislation

	<u>2003 Amount Authorized</u>	<u>2003 President's Budget</u>	<u>2004 Amount Authorized</u>	<u>2004 Budget Request</u>
<u>Home Energy Assistance Activity:</u>				
Section 2602(b) of the Low Income Home Energy Assistance Act of 1981, as amended.	Such sums	\$1,372,200,000	Such sums	\$1,672,200,000
Leveraging Incentive Fund, Section 2602(d) of the Low Income Home Energy Assistance Act of 1981, as amended	30,000,000	27,500,000	30,000,000	27,500,000
Energy Emergency Contingency Fund, Section 2602(e) of the Low Income Home Energy Assistance Act of 1981, as amended.	600,000,000	300,000,000	600,000,000	300,000,000
Training and Technical Assistance, from funds made available under Section 2602(b) of the Low Income Home Energy Assistance Act of 1981, as amended	300,000	300,000	300,000	300,000
Appropriation		\$1,700,000,000		\$2,000,000,000

Low Income Home Energy Assistance Program

APPROPRIATIONS HISTORY TABLE

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1995 ¹	1,475,000,000	1,475,000,000	1,475,000,000	1,475,000,000
Emergency Funding	---	[600,000,000]	[600,000,000]	[600,000,000]
Rescission	(50,000,000)	(250,000,000)	(89,592,000)	(155,896,000)
Admin. Reduction	---	---	---	(1,521)
1996 - Appropriated in FY 95 for obligation in FY 96	1,319,204,000	1,319,204,000	1,319,204,000	1,319,204,000
Emergency Funding	---	---	---	[300,000,000]
Rescission	---	---	---	(319,204,000)
Further Reduction	---	(1,000,000,000)	(100,000,000)	(100,000,000)
Admin. Reduction	---	---	---	(2,500)
Emergency Sup.	---	180,000,000	180,000,000	180,000,000
1997	1,000,000,000	1,000,000,000	1,000,000,000	1,000,000,000
Emergency Funding ²	[300,000,000]	[300,000,000]	[300,000,000]	[420,000,000]
Emergency Funds Disbursed ³	---	---	---	215,000,000
1998 - Appropriated in FY 97 for obligation in FY 98	1,000,000,000	1,000,000,000	1,000,000,000	1,000,000,000
Emergency Funding	[300,000,000]	[300,000,000]	[300,000,000]	
Emergency Funds Disbursed	---	---	---	160,000,000 ⁴
1999 - Appropriated in FY 98 for obligation in FY 99	1,000,000,000	1,000,000,000	1,200,000,000	1,100,000,000
House Action on Advance Funding	---	(1,100,000,000)	---	1,100,000,000

¹ Of the amount appropriated for FY 95, it was requested that \$745,000,000 be made available in the period October 1, 1995 through September 30, 1996, with the balance of \$730,000,000 available October 1, 1994 through September 30, 1995. Congress did not approve this request.

² In addition to the \$300,000,000 in emergency contingency funds made in FY 96 for FY 97, Congress added the balance of FY 96 funds (\$120,000,000) neither formally appropriated nor obligated in FY 96.

³ \$5,000,000 released to North and South Dakota January 15, 1997; the balance released to all states January 31, with special relief for eight mid-west states hardest hit by particularly cold weather.

⁴ Because of extreme and life-threatening hot weather, \$150,000,000 was released during the summer of 1998 to: Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas. In addition, \$10,000,000 was released to Alaska to buy fuel oil for the coming winter for villages facing high heating costs that were difficult to meet due to the disastrously low salmon run.

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
Emergency Funding ⁵	[300,000,000]	[300,000,000]	[300,000,000]	[300,000,000]
Reallocation of PY				
Funds	---	---	---	2,207,431
Emergency Funds				
Disbursed	---	---	---	175,298,765 ⁶
2000				
Emergency Sup.	---	---	---	600,000,000
Emergency Funds				
Disbursed	---	---	---	744,350,000 ⁷
2001 – Appropriated in FY 00 for obligation in FY 01	1,100,000,000	1,100,000,000	1,100,000,000	1,100,000,000
Regular Appro.	---	---	---	300,000,000
Emergency Funding	[300,000,000]	[300,000,000]	[300,000,000]	[300,000,000]
Emergency Suppl.	---	300,000,000	300,000,000	300,000,000
Emergency Funds				
Disbursed	---	---	---	455,650,000 ⁸
2002	1,100,000,000	1,100,000,000	---	---
Emergency Funding	[300,000,000]	[300,000,000]	[300,000,000]	[300,000,000]
Emergency Sup.				
Carryover from FY 01	---	---	---	[300,000,000]
Emergency Funds				
Disbursed	---	---	---	100,000,000
2003	1,400,000,000			
Emergency Funding	[300,000,000]			
Emergency Sup.				
Carryover from FY 01	---	---	---	[300,000,000]
Emergency Sup.				
Funds Disbursed	---	---	---	200,000,000
Emergency Funds				
Disbursed	---	---	---	---

⁵ Advance Funding requested in FY 99 for FY 00.

⁶ Due to excessively hot weather during late June and early July of 1999, \$100 million was released to 17 eastern states and the District of Columbia, including 15 Indian tribes. In August, an additional \$55 million was released to 9 additional states that had experienced extreme heat. In September, \$29,298,765 was released to North Carolina to assist with energy-related flood damage.

⁷ In October 1999, \$5,000,000 was released to New Jersey to assist with energy-related damage due to Hurricane Floyd. In January 2000, \$45,000,000 was released to 11 States who depend heavily on heating oil and liquid petroleum, whose costs were higher than the previous year's. By the end of the fiscal year, \$744,350,000 had been released to offset the increasing costs of fuel.

⁸ The emergency supplemental for FY 2001 was available until expended. A balance of \$155,650,000 was carried over into FY 2001 and that amount, together with the \$300,000,000 in new budget authority for emergency contingencies, had been obligated by the end of December 2000 to offset continuing increases in fuel prices and an unusually cold November and December.

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
2004	1,700,000,000			
Emergency Funding	[300,000,000]			
Emergency Sup.				
Carryover from FY 01	---	---	---	[100,000,000]
Emergency Funds				
Disbursed	---	---	---	---

Low Income Home Energy Assistance Program

Justification

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Program Grants	\$1,672,200,000	\$1,372,200,000	\$1,672,200,000	\$0
Leveraging Grants	27,500,000	27,500,000	27,500,000	0
Subtotal	1,699,700,000	1,399,700,000	1,699,700,000	0
Contingency Fund	300,000,000	300,000,000	300,000,000	0
Training and Technical Assistance	300,000	300,000	300,000	0
Contingency Funds Released	[100,000,000]	[200,000,000]	NA	NA
Total, BA	\$2,000,000,000	\$1,700,000,000	\$2,000,000,000	0

General Statement

Consistent with the Administration for Children and Families' strategic goal to build healthy, safe and supportive communities and tribes, the Low Income Home Energy Assistance Program (LIHEAP) provides assistance to low income households in meeting the costs of home energy heating and cooling their homes.

Approximately 24 percent of LIHEAP recipients are "working poor" households that do not receive any other public assistance through TANF, food stamps, SSI, or subsidized housing. Approximately 35 percent of LIHEAP recipients are elderly households. LIHEAP funds are not intended to meet the entire home energy costs of low-income households. Rather, LIHEAP funds are intended to supplement other available Federal assistance as well as the households' own resources and State resources.

Legislation enacted in 1994 made it easier for States to use LIHEAP funds more effectively to target assistance to households with high energy burdens or need and authorized States to use a portion of their funds to assist households in reducing their need for home energy. Through a collaborative process to develop performance objectives and measures, States increasingly are targeting resources more effectively.

A leveraging incentive fund has been successful in encouraging States to develop increased non-Federal energy assistance resources to be used in conjunction with LIHEAP funds. Beginning in FY 1996, a new Residential Energy Assistance Challenge Grant program (REACH) became a component of the leveraging incentive fund. It assists a limited number of LIHEAP grantees in developing and operating programs to help LIHEAP-eligible households reduce their energy vulnerability.

The COATS Human Services Reauthorization Act of 1998 (Public Law 105-285) reauthorized this program for FY 2000 through FY 2004, at a level of "such sums" for FY 2000 and FY 2001, and at \$2 billion for FY 2002 through FY 2004. This legislation increased the allowable set-aside for training and technical assistance from \$250,000 to \$300,000, extended on a permanent basis the authority to set aside up to 25 percent of the funds earmarked for leveraging incentive award program, and directed the Comptroller General to conduct an evaluation of the REACH program.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

Authorizing Legislation – Section 2602(b) of the Low Income Home Energy Assistance Act of 1981, as amended, P.L.97-35.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$1,700,000,000	\$1,400,000,000	\$1,700,000,000	+\$300,000,000

2004 Authorization....\$2,000,000,000.

Purpose and Method of Operation

The Low Income Home Energy Assistance Program provides home energy assistance to low-income households through payments to eligible households and to energy suppliers. Funds are provided through block grants to States, Indian tribes and tribal organizations, Puerto Rico and four other territories for their use in programs tailored to meet the unique requirements of their jurisdictions. This program assists eligible households in meeting the costs of home energy, defined by the statute to include sources of residential heating and cooling.

The statute allows States to make payments to, or on behalf of, eligible households meeting one of the following criteria:

- Receipt of assistance under Title IV-A of the Social Security Act, Supplemental Security Income payments, Food Stamps, or certain needs-based veterans benefits; or
- Household total income does not exceed the higher of 150 percent of the poverty level or 60 percent of the State median income level. States may establish lower income eligibility criteria, but they may not exclude households with incomes below 110 percent of the poverty level solely on the basis of income.

States may give priority to households with the highest home energy costs or need in relation to income. States are allowed flexibility in determining payment levels and types of payments, including unrestricted cash payments, payments to vendors on behalf of eligible households, or energy vouchers. Generally States elect to provide benefits in the form of payments to vendors on behalf of recipient households.

Up to ten percent of the funds payable to a State may be used to pay planning and administrative costs. A grantee may hold up to ten percent of the funds payable to it for obligation in the subsequent year.

Beginning in FY 1992, a portion of the appropriation may be made available to reward those grantees that leverage their Federal LIHEAP dollars so that they cover more services or benefits.

Funding for the Low Income Home Energy Assistance Program during the last five years, exclusive of contingency funds, has been as follows:

1999 (advance appropriation in FY 1998)	\$1,000,000,000
2000 (advance appropriation in FY 1999)	\$1,100,000,000
2001 (advance appropriation in FY 2000)	\$1,100,000,000
2001 (regular appropriation)	\$300,000,000
2002 (regular appropriation)	\$1,700,000,000
2003 (regular appropriation)	\$1,400,000,000

Rationale for the Budget Request

In order to continue to provide home energy assistance, \$1,700,000,000 is requested for FY 2004, an increase of \$300,000,000 over the FY 2003 President's Budget. This increase will enable states to meet energy emergencies due to extremes in temperature, either during severe cold weather in the winter or sustained heat waves in the summer. This request will help enable states to meet the increasing demands for LIHEAP assistance, ensure that low income households are not without heating or cooling, and provide protection to our most vulnerable populations, the elderly, households with small children and persons with disabilities.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Low Income Home Energy Assistance Program--Block Grants (CFDA # 93.568)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$14,284,628	\$11,719,518	\$14,281,721	\$2,562,203
Alaska	6,373,367	6,454,070	7,865,105	1,411,035
Arizona	6,378,521	5,236,542	6,381,392	1,144,850
Arkansas	10,959,034	8,992,936	10,959,034	1,966,098
California	76,505,203	62,771,378	76,494,897	13,723,519
Colorado	26,839,585	22,019,960	26,839,584	4,819,624
Connecticut	35,045,798	28,758,429	35,045,798	6,287,369
Delaware	4,651,655	3,817,128	4,651,655	834,527
District of Columbia	5,442,670	4,466,231	5,442,670	976,439
Florida	22,716,478	18,643,487	22,719,457	4,075,970
Georgia	17,967,820	14,744,314	17,967,820	3,223,506
Hawaii	1,809,458	1,484,834	1,809,458	324,624
Idaho	10,307,123	8,457,980	10,307,123	1,849,143
Illinois	97,000,718	79,598,364	97,000,718	17,402,354
Indiana	43,909,300	36,033,239	43,912,536	7,879,297
Iowa	31,126,126	25,541,963	31,126,126	5,584,163
Kansas	14,282,663	11,718,165	14,282,663	2,564,498
Kentucky	22,855,403	18,755,044	22,855,403	4,100,359
Louisiana	14,683,141	12,048,921	14,683,141	2,634,220
Maine	21,874,256	17,949,919	21,874,256	3,924,337
Maryland	26,834,125	22,019,965	26,834,125	4,814,160
Massachusetts	70,075,161	57,503,370	70,075,161	12,571,791
Michigan	91,680,099	75,223,552	91,669,453	16,445,901
Minnesota	66,348,286	54,445,113	66,348,286	11,903,173
Mississippi	12,292,778	10,087,400	12,292,778	2,205,378
Missouri	38,745,874	31,794,695	38,745,874	6,951,179
Montana	10,430,204	8,558,981	10,430,204	1,871,223
Nebraska	15,389,463	12,627,881	15,389,463	2,761,582
Nevada	3,262,202	2,676,949	3,262,202	585,253
New Hampshire	13,269,106	10,888,570	13,269,106	2,380,536
New Jersey	64,917,211	53,270,779	64,917,211	11,646,432
New Mexico	8,043,979	6,600,853	8,043,979	1,443,126
New York	212,125,965	174,069,875	212,172,245	38,102,370
North Carolina	31,159,322	25,569,204	31,159,322	5,590,118
North Dakota	10,921,884	8,838,640	10,771,006	1,932,366

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	85,811,633	70,416,650	85,811,633	15,394,983
Oklahoma	11,998,086	9,917,026	12,088,607	2,171,581
Oregon	20,712,188	16,954,176	20,663,440	3,709,264
Pennsylvania	114,141,586	93,664,086	114,141,586	20,477,500
Rhode Island	11,506,691	9,442,339	11,506,691	2,064,352
South Carolina	11,406,510	9,360,132	11,406,510	2,046,378
South Dakota	8,916,026	7,316,453	8,916,026	1,599,573
Tennessee	23,152,034	18,998,458	23,152,034	4,153,576
Texas	37,807,287	31,024,494	37,807,287	6,782,793
Utah	12,241,787	10,032,234	12,251,787	2,219,553
Vermont	9,945,667	8,161,371	9,945,667	1,784,296
Virginia	32,686,964	26,822,780	32,686,964	5,864,184
Washington	32,886,631	26,963,492	32,858,445	5,894,953
West Virginia	15,125,156	12,411,637	15,125,156	2,713,519
Wisconsin	59,722,984	49,008,419	59,722,984	10,714,565
Wyoming	4,998,337	4,041,726	4,925,361	883,635
Subtotal	1,653,568,173	1,357,923,722	1,654,891,150	296,967,428
Tribes	16,367,200	12,417,935	15,044,223	2,626,288
American Samoa	37,463	30,741	37,463	6,722
Guam	82,135	67,399	82,135	14,736
Northern Mariana Islands	28,528	23,409	28,528	5,119
Puerto Rico	2,038,833	1,673,062	2,038,833	365,771
Virgin Islands	77,668	63,732	77,668	13,936
Subtotal	18,631,827	14,276,278	17,308,850	3,032,572
Total States/Territories	1,672,200,000	1,372,200,000	1,672,200,000	300,000,000
Discretionary Funds	27,500,000	27,500,000	27,500,000	0
Technical Assistance	300,000	300,000	300,000	0
Subtotal adjustments	27,800,000	27,800,000	27,800,000	0
TOTAL RESOURCES	\$1,700,000,000	\$1,400,000,000	\$1,700,000,000	\$0

LOW INCOME HOME ENERGY ASSISTANCE CONTINGENCY FUND

Authorizing Legislation -- Section 2602(e) and 2604(g) of the Low Income Home Energy Assistance Act of 1981, as amended.

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Appropriation	\$300,000,000	\$300,000,000	\$300,000,000	\$0
Contingency Funds Released	100,000,000	200,000,000	NA	NA
Contingency Funds Available	[\$300,000,000] ¹	[\$100,000,000] ¹	[\$100,000,000] ¹	\$0

2004 Authorization....\$600,000,000.

Purpose and Method of Operation

Consistent with the ACF goal to target energy assistance, this program is designed to provide additional funds to States that are adversely affected by extreme heat or cold, or other causes of energy-related emergencies. The 1994 amendments to the authorizing statute added language to provide a permanent authorization for the emergency fund and to permit targeting of grants to meet emergency needs. In FY 1995 through FY 2002, contingency funds have been requested, and at least a portion has been released each year.

Funding for the Low Income Home Energy Assistance Contingency Fund during the last five years has been as follows:

1999	(\$300,000,000)
1999 funds distributed	\$175,298,765
2000	(\$900,000,000)
2000 funds distributed	\$744,350,000
2001	(\$755,650,000) ²
2001 funds distributed	\$455,650,000
2002	(\$300,000,000)
2002 funds available to be distributed	(\$500,000,000)
2002 funds distributed	\$100,000,000
2003	(\$300,000,000)
2003 funds available to be distributed	(\$400,000,000)
2003 funds distributed	\$200,000,000

¹ \$300,000,000 was made available in a supplemental in FY 2001, to remain available until expended. \$200M was released in January, 2003 due to higher than normal energy prices, especially home heating oil.

² Of this amount, \$300,000,000 was made available in a supplemental, to remain available until expended. A balance of \$155,650,000 was carried over into FY 2001.

Rationale for the Budget Request

The FY 2004 request for the Contingency Fund is \$300,000,000, the same as the FY 2003 President's Budget. In addition, of the \$300,000,000 appropriated in a supplemental in FY 2001, \$100,000,000 remains available for use in FY 2003. Because it is not possible to predict natural disasters of areas of the country which might sustain periods of unusual heat or cold, \$300,000,000 is requested for contingencies. Any unexpended contingency funds in FY 2003 will remain available in FY 2004.

Resource and Program Data
Low Income Home Energy Assistance Program

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$1,672,200,000	\$1,372,200,000	\$1,672,200,000
Leveraging	20,625,000	20,625,000	20,625,000
REACH	6,875,000	6,875,000	6,875,000
Contingency Funds	[300,000,000]	300,000,000	300,000,000
Contingency Funds Released	100,000,000	[200,000,000]	NA
Contingency Funds Available from Prior Years	[300,000,000] ¹	[100,000,000]	[100,000,000]
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	215,594	288,000	288,000
Program Support ²	84,406	12,000	12,000
Total, Resources	\$1,800,000,000	\$1,700,000,000	\$2,000,000,000
<u>Program Data:</u>			
Number of Grants	361	281	281
New Starts:			
#	350	270	270
\$	\$1,799,435,171	\$1,399,435,171 ³	\$1,399,435,171 ³
Continuations:			
#	11	11	11
\$	\$264,829	\$264,829	\$264,829
Contracts:			
#	4	3	3
\$	\$220,534	\$225,000	\$225,000
Interagency Agreements:			
#	3	2	2
\$	\$68,155	\$63,000	\$63,000

¹ \$300,000,000 was made available in a supplemental in FY 2001, to remain available until expended. \$200M was released in January, 2003 due to higher than normal energy prices, especially home heating oil.

² This includes funding for information technology support, grant/panel review and printing costs.

³ Does not reflect release of contingency funds since no decisions have been made at this time.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

**PROGRAM: Low Income Home Energy Assistance Program—Contingency Funds
(CFDA #93.568)**

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$0	\$1,085,372	n/a	n/a
Alaska	0	1,299,683	n/a	n/a
Arizona	1,673,521	462,357	n/a	n/a
Arkansas	0	793,720	n/a	n/a
California	0	5,548,701	n/a	n/a
Colorado	1,994,730	1,948,680	n/a	n/a
Connecticut	1,604,928	6,908,830	n/a	n/a
Delaware	353,989	867,954	n/a	n/a
District of Columbia	299,513	537,929	n/a	n/a
Florida	0	1,942,341	n/a	n/a
Georgia	0	1,396,842	n/a	n/a
Hawaii	0	130,604	n/a	n/a
Idaho	878,039	985,043	n/a	n/a
Illinois	8,173,095	7,487,253	n/a	n/a
Indiana	3,711,662	3,960,848	n/a	n/a
Iowa	1,118,669	2,742,905	n/a	n/a
Kansas	1,008,515	1,037,998	n/a	n/a
Kentucky	3,196,722	2,011,539	n/a	n/a
Louisiana	0	1,071,167	n/a	n/a
Maine	0	5,567,518	n/a	n/a
Maryland	1,579,579	3,808,774	n/a	n/a
Massachusetts	4,195,456	12,272,222	n/a	n/a
Michigan	7,694,005	8,362,344	n/a	n/a
Minnesota	2,257,327	7,626,531	n/a	n/a
Mississippi	0	901,208	n/a	n/a
Missouri	2,308,716	2,957,449	n/a	n/a
Montana	498,675	870,335	n/a	n/a
Nebraska	1,400,140	1,230,905	n/a	n/a
Nevada	1,312,645	263,451	n/a	n/a
New Hampshire	0	2,951,570	n/a	n/a
New Jersey	4,786,974	10,330,192	n/a	n/a
New Mexico	0	583,707	n/a	n/a
New York	15,825,801	36,711,213	n/a	n/a
North Carolina	4,019,313	4,651,264	n/a	n/a
North Dakota	385,013	1,270,000	n/a	n/a

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	8,732,990	7,797,095	n/a	n/a
Oklahoma	0	871,518	n/a	n/a
Oregon	1,628,266	2,021,690	n/a	n/a
Pennsylvania	7,244,772	16,469,576	n/a	n/a
Rhode Island	786,593	2,046,693	n/a	n/a
South Carolina	1,940,719	1,367,982	n/a	n/a
South Dakota	460,584	989,821	n/a	n/a
Tennessee	0	2,007,525	n/a	n/a
Texas	0	2,735,094	n/a	n/a
Utah	935,694	942,294	n/a	n/a
Vermont	0	2,128,885	n/a	n/a
Virginia	3,139,645	4,653,087	n/a	n/a
Washington	0	3,060,200	n/a	n/a
West Virginia	1,210,876	1,429,584	n/a	n/a
Wisconsin	2,702,967	6,661,621	n/a	n/a
Wyoming	327,359	360,809	n/a	n/a
Subtotal	99,387,492	198,121,923	0	0
Tribes	612,508	1,715,563	n/a	n/a
American Samoa	0	2,688		
Guam	0	5,894		
Northern Marianas	0	2,047		
Puerto Rico	0	146,311		
Virgin Islands	0	5,574		
Subtotal	612,508	1,878,077	0	0
Total States/Territories	100,000,000	200,000,000	0	0
TOTAL RESOURCES	\$100,000,000	\$200,000,000¹	\$300,000,000	

¹ \$300,000,000 was made available in a supplemental in FY 2001, to remain available until expended. \$200M was released in January, 2003 due to higher than normal energy prices, especially home heating oil. \$100M remains available in FY 2004 if not released in FY 2003.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Child Care and Development Block Grant

FY 2004 Budget	Page
Appropriation Language	G-2
Amounts Available for Obligation	G-3
Summary of Changes	G-4
Budget Authority by Activity	G-5
Budget Authority by Object	G-5
Significant Items in House, Senate, and Conference Appropriations Committee Reports.....	G-6
Authorizing Legislation	G-7
Appropriations History Table	G-8
Justification:	
General Statement	G-9
Child Care and Development Block Grant	G-11
Research and Evaluation Fund	G-16

ADMINISTRATION FOR CHILDREN AND FAMILIES
Payments to States for Child Care and Development Block Grant

For carrying out sections 658A through 658R of the Omnibus Budget Reconciliation Act of 1981 (The Child Care and Development Block Grant Act of 1990), [\$2,099,994,000] \$2,099,729,000 shall be used to supplement, not supplant state general revenue funds for child care assistance for low-income families: *Provided*, That \$19,120,000 shall be available for child care resource and referral and school-aged child care activities, of which \$1,000,000 shall be for the Child Care Aware toll-free hotline: *Provided further*, That in addition to the amounts required to be reserved by the States under section 658G, \$272,672,000 shall be reserved by the States for activities authorized under 658G of which \$100,000,000 shall be for activities that improve the quality of infant and toddler care: *Provided further*, That [\$10,000,000] \$9,864,000 shall be for use by the Secretary for child care research, demonstration, and evaluation activities.

*Departments of Labor, Health and Human Services, and Education, and Related Agencies
Appropriations Act, 2003, as proposed in the FY 2003 President's Budget*

Child Care and Development Block Grant

Amounts Available for Obligation

	<u>2002 Actual</u>	<u>2003 President's Budget</u>	<u>2004 Estimate</u>
Child Care and Development Block Grant	\$2,089,994,000	\$2,089,994,000	\$2,089,865,000
Research and Evaluation Fund	10,000,000	10,000,000	9,864,000
Enacted Rescission	-52,000		
Subtotal, Adjusted Appropriation	\$2,099,942,000	\$2,099,994,000	\$2,099,729,000
Total Obligations	\$2,099,942,000	\$2,099,994,000	\$2,099,729,000

Child Care and Development Block Grant

SUMMARY OF CHANGES

FY 2003 President's Budget Request.....	\$2,099,994,000
Total estimated budget authority	\$2,099,994,000
(Obligations)	\$2,099,994,000
 FY 2004 Estimate	 \$2,099,729,000
(Obligations).....	\$2,099,729,000
Net change	-\$265,000
(Obligations).....	-\$265,000

	FY 2003 President's Budget Base	Change from Base
Decreases:		
A. Program:		
1. Information technology reduction to Child Care Development Block Grant base program	\$2,089,994,000	-\$129,000
2. Information technology reduction to Research and Evaluation fund in CCDBG base program	\$10,000,000	-\$136,000
Net Change.....		-\$265,000

Child Care and Development Block Grant

Budget Authority by Activity

	<u>2002 Actual</u>	<u>2003 President's Budget</u>	<u>2004 Estimate</u>
Child Care and Development Block Grant	\$2,089,970,000	\$2,089,994,000	\$2,089,865,000
Research and Evaluation Fund	9,972,000	10,000,000	9,864,000
Total, BA	\$2,099,942,000	\$2,099,994,000	\$2,099,729,000

Budget Authority by Object

	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase or Decrease</u>
Advisory and assistance services (25.1).....	\$5,739,000	\$5,474,000	-\$265,000
Purchase of goods and services from government accounts (25.3).....	1,500,000	1,500,000	\$0
Grants, subsidies and contributions (41.0).....	2,092,755,000	2,092,755,000	\$0
Total, BA	\$2,099,994,000	\$2,099,729,000	-\$265,000

ADMINISTRATION FOR CHILDREN AND FAMILIES

Child Care and Development Block Grant

SIGNIFICANT ITEMS IN HOUSE, SENATE AND CONFERENCE
APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2003 Congressional requirements for reports and significant items derived from Senate Report 107-216 (Labor, Health and Human Services and Education (L/HHS/E). These actions discussed below are contingent on inclusion of similar language and funding in the final FY 2003 appropriation and related reports. Additional items may be transmitted at a later date as a result of the final Conference report.

2003 Senate Committee Report LanguageItem

Before and after-school set-aside – The Committee recommendation provides \$19,120,000 for the purposes of supporting resource and referral programs and before and afterschool services. This represents the Federal commitment to the activities previously funded under the dependent care block grant. The Committee further expects that these funds will not supplant current funding dedicated to resource and referral and school age activities provided by the child care and development block grant. The Committee strongly encourages States to address the matters of before and afterschool care and the establishment of resource and referral programs with the funds provided in this program.

Action Taken or to be Taken

The Child Care Bureau is informing State and Tribal Child Care Lead Agencies of the before-and-after-school and resource and referral earmark. The Bureau is providing a chart that lists the dollar amount of the earmark for each State and Tribe. This is a continuation of a previously established earmark.

Child Care and Development Block Grant

Authorizing Legislation

	2003 Amount <u>Authorized</u>¹	2003 President's <u>Budget</u>	2004 Amount <u>Authorized</u>	2004 Budget <u>Request</u>
Sections 658A through 658S of the Omnibus Budget Reconciliation Act of 1981, as added by P.L. 101-508, amended by P.L. 102-586, P.L. 103-171 and P.L. 104-193.	\$2,099,994,000	\$2,099,994,000	\$2,099,994,000	\$2,099,729,000

¹ Reflects authorization level for this program as proposed in the President's FY 2003 Budget Request.

APPROPRIATIONS HISTORY TABLE
Child Care and Development Block Grant

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1994 ¹	958,964,000	892,711,000	892,711,000	892,711,000
1995 ²	1,090,662,000	934,642,000	934,642,000	934,642,000
1996	1,048,825,000	934,642,000	934,642,000 ³	934,642,000
1997	1,048,825,000	950,000,000	956,120,000	956,120,000
1998	65,672,000	937,000,000	963,120,000	1,002,672,000
1999	1,182,672,000	1,000,000,000	1,000,000,000	999,974,000
2000	1,182,672,000	1,182,672,000	1,182,672,000	1,182,672,000
2001				
Advance	1,182,672,000	1,182,672,000	1,182,672,000	1,182,672,000
Appropriation	817,328,000	400,000,000	817,328,000	817,196,000
Advance FY02	2,000,000,000	2,000,000,000	0	0
2002	2,199,987,000	2,199,987,000	2,000,000,000	2,099,976,000
<i>Rescission</i>				-15,000
				2,042,000,000
2003	2,099,994,000			
2004	2,099,729,000			

¹ The Budget Estimate to Congress included \$932,711,000 for CCDBG, \$1,372,000 for Child Development Associate Scholarships, \$11,942,000 for Temporary Child Care Nurseries and \$12,939,000 for Dependent Care Planning and Development Grants.

² The Budget Estimate to Congress included \$1,090,662,000 for CCDBG and \$0 for Dependent Care Planning and Development Grants. Both the House and Senate allowance included \$934,656,000 for CCDBG, which was reduced to \$934,642,000 pursuant to P.L. 103-333. In addition, Congress separately provided \$1,360,000 for Child Development Associate Scholarships and \$12,823,000 for Dependent Care Planning and Development Grants.

³ Senate Committee Mark.

Child Care and Development Block Grant

Justification

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Child Care and Development Block Grant	\$2,089,970,000	\$2,089,994,000	\$2,089,865,000	-\$129,000
Research and Evaluation Fund	9,972,000	10,000,000	9,864,000	-\$136,000
Total, BA	\$2,099,942,000	\$2,099,994,000	\$2,099,729,000	-\$265,000

General Statement

The Child Care and Development Block Grant was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) as a discretionary funded program. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. 104-193) made changes to this program by combining the child care entitlement programs (AFDC Child Care, Transitional Child Care and At-Risk Child Care) into the Child Care and Development Block Grant (CCDBG) Act of 1990, as amended. The entitlement portion consisted of mandatory and matching funds made available under section 418 of the Social Security Act, while the discretionary funding was authorized by the Child Care and Development Block Grant Act. The combined funding from these streams was designated the Child Care and Development Fund (CCDF).

The Child Care and Development Block Grant makes funds available for child care services and activities to improve the availability, accessibility, and affordability of child care. The program allows States maximum flexibility in developing child care programs and enables States to use resources most effectively to meet local needs. Child care subsidies funded through the Block Grant assist low-income families who are working or attending training/education. A minimum of four percent of funds are set aside for activities to provide comprehensive consumer education to parents and the public, activities that increase parental choice and activities designed to improve the quality and availability of child care (such as implementing State health and safety and licensing regulations and resource and referral services). Additional appropriation earmarks also designate funds for improving the quality and availability of care. Quality child care promotes literacy and prepares children to succeed in school.

Two percent of the funds are reserved for Indian tribes, and one half of one percent is reserved for the Territories. A quarter of a percent is reserved for technical assistance. The FY 2004

request reduces the amount included for research and evaluation to \$9,864,000, which will promote the generation of critically-needed information for and about parents, children, and the child care market.

CHILD CARE AND DEVELOPMENT BLOCK GRANT

Authorizing Legislation – Legislation to reauthorize the Child Care and Development Block Grant Act of 1990 is pending congressional action.

2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
\$2,089,970,000	\$2,089,994,000	\$2,089,865,000	-\$129,000

2004 Authorization.....\$2,089,994,000 (reflects authorization level for this program as proposed in the President's FY 2003 Budget Request and legislative proposal pending congressional action).

Purpose and Method of Operation

The Child Care and Development Block Grant provides grants to States, federally recognized Tribes, and Territories for the purposes of: providing low-income families with financial assistance for child care; improving the quality and availability of child care; and establishing or expanding and conducting early child development programs and before-and after-school programs. The program allows States and communities to use resources effectively and responsively to meet local needs.

Federal funds enable States, Tribes and Territories to provide child care services through grants, contracts, and certificates to low-income families with a parent who is working or attending a training or educational program. Certificates allow parents to place their children in the care of the provider of their choice, whether it is center-based care, a family home provider, or relative care, including community-based or faith-based child care programs. This program is designed to help low-income families succeed at work and therefore remain self-sufficient.

Comparable funding for the Child Care and Development Block Grant program for the past five years, has been as follows:

1999.....	\$999,974,000
2000.....	\$1,172,672,000
2001.....	\$1,989,927,500
2002.....	\$2,089,970,000
2003 (President's budget request)	\$2,089,994,000

These child care funds will:

- Allow each State maximum flexibility in developing child care programs and policies that best suit the needs of children and parents within each State;

- Promote parental choice to empower working parents to make their own decisions on child care that best suits their family's needs;
- Encourage States to provide consumer education information to help parents make informed choices about child care;
- Assist States in providing child care to parents trying to achieve and maintain independence from public assistance and assist other low-income working parents to maintain quality child care services for their children; and
- Assist States in implementing the health, safety, licensing, and registration standards established in State regulations.

Rationale for the Budget Request

The FY 2004 request of \$2,089,865,000 -- a \$129,000 decrease to the level of funding provided in the President's FY 2003 budget request -- will provide funding to assist States in meeting the critical child care needs of families. The Child Care and Development Block Grant helps States and communities to build the supply of high quality, affordable child care. The funds will continue ACF's commitment to providing resources that allow families to become and remain self-sufficient and productive members of society. These funds also allow families to access quality child care, which promotes child development, literacy, and school readiness. All segments of society -- parents, schools, employers, health providers, faith-based institutions and other charitable agencies, States and the federal government -- must be involved to ensure access to quality child care.

Resource and Program Data
Child Care and Development Block Grant

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$2,084,729,015	\$2,084,744,015	\$2,084,744,015
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	5,240,985	5,249,985	5,120,985
Program Support			
Total, Resources	\$2,089,970,000	\$2,089,994,000	\$2,089,865,000
Program Data:			
Number of Grants	319	316	316
New Starts:			
#			
\$			
Continuations:			
#	319	316	316
\$	\$2,084,729,015	\$2,084,744,015	\$2,084,744,015
Contracts:			
#	4	4	4
\$	\$5,240,985	\$5,249,985	\$5,120,985
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: CCDF Discretionary (CFDA # 93.575)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$42,929,737	\$41,897,072	\$41,897,072	\$0
Alaska	4,077,745	4,268,512	4,268,512	0
Arizona	43,481,082	45,868,249	45,868,249	0
Arkansas	25,553,862	25,040,798	25,040,798	0
California	243,602,191	239,514,827	239,514,827	0
Colorado	23,216,949	23,168,788	23,168,788	0
Connecticut	15,516,200	15,111,453	15,111,453	0
Delaware	4,425,363	4,478,701	4,478,701	0
District of Columbia	3,575,717	3,640,004	3,640,004	0
Florida	105,495,897	110,304,573	110,304,573	0
Georgia	69,949,985	71,558,036	71,558,036	0
Hawaii	8,044,428	8,463,788	8,463,788	0
Idaho	11,558,158	11,310,713	11,310,713	0
Illinois	78,610,865	79,574,579	79,574,579	0
Indiana	39,634,316	40,331,418	40,331,418	0
Iowa	18,910,604	19,267,406	19,267,406	0
Kansas	18,966,933	20,170,628	20,170,628	0
Kentucky	37,296,800	36,177,433	36,177,433	0
Louisiana	51,717,684	49,481,104	49,481,104	0
Maine	7,952,708	7,796,554	7,796,554	0
Maryland	27,855,834	27,990,613	27,990,613	0
Massachusetts	28,623,370	28,037,947	28,037,947	0
Michigan	60,683,562	60,653,416	60,653,416	0
Minnesota	27,017,650	26,780,357	26,780,357	0
Mississippi	34,880,544	34,048,099	34,048,099	0
Missouri	38,897,572	39,637,710	39,637,710	0
Montana	6,447,972	6,218,681	6,218,681	0
Nebraska	11,693,011	11,876,718	11,876,718	0
Nevada	10,855,892	11,789,090	11,789,090	0
New Hampshire	5,342,257	5,180,262	5,180,262	0
New Jersey	39,728,574	39,450,950	39,450,950	0
New Mexico	19,313,705	18,911,215	18,911,215	0
New York	117,149,059	117,163,222	117,163,222	0
North Carolina	59,839,819	62,110,482	62,110,482	0
North Dakota	4,636,540	4,474,481	4,474,481	0

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	69,347,042	69,622,853	69,622,853	0
Oklahoma	32,478,555	31,516,053	31,516,053	0
Oregon	21,693,453	22,353,501	22,353,501	0
Pennsylvania	65,737,635	66,212,834	66,212,834	0
Rhode Island	5,608,803	5,759,819	5,759,819	0
South Carolina	38,362,704	37,265,321	37,265,321	0
South Dakota	6,239,240	6,167,081	6,167,081	0
Tennessee	44,213,390	45,389,967	45,389,967	0
Texas	202,599,171	202,216,611	202,216,611	0
Utah	21,355,203	20,955,388	20,955,388	0
Vermont	3,452,257	3,381,089	3,381,089	0
Virginia	40,870,368	40,441,451	40,441,451	0
Washington	34,994,466	34,324,150	34,324,150	0
West Virginia	15,110,217	14,399,584	14,399,584	0
Wisconsin	31,004,615	31,084,542	31,084,542	0
Wyoming	3,320,644	3,223,414	3,223,414	0
Subtotal	1,983,870,348	1,986,061,537	1,986,061,537	0
Tribes	42,999,880	42,999,880	42,999,880	0
American Samoa	2,663,480	2,663,472	2,663,472	0
Guam	4,000,757	4,000,745	4,000,745	0
Northern Mariana Islands	1,636,489	1,636,520	1,636,520	0
Puerto Rico	47,373,817	45,182,628	45,182,628	0
Virgin Islands	2,199,244	2,199,233	2,199,233	0
Subtotal	100,873,667	98,682,478	98,682,478	0
Total States/Territories	2,084,744,015	2,084,744,015	2,084,744,015	0
Technical Assistance	5,225,985	5,249,985	5,120,985	129,000
Research Set-Aside	9,972,000	10,000,000	9,864,000	136,000
Subtotal	15,197,985	15,249,985	14,984,985	265,000
Adjustments				
TOTAL RESOURCES	\$2,099,942,000	\$2,099,994,000	\$2,099,729,000	\$265,000

1/ In FY 2003 and 2004 includes \$1,000,000 for Child Care Aware.

RESEARCH AND EVALUATION FUND

Authorizing Legislation -- Legislation to reauthorize the Child Care and Development Block Grant Act of 1990 is pending congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$9,972,000	\$10,000,000	\$9,864,000	-\$136,000

2004 Authorization.....\$10,000,000 (reflects authorization level for this program as proposed in the President's FY 2003 Budget Request and legislative proposal pending congressional action).

Purpose and Method of Operation

In accordance with ACF's goal of ensuring healthy, safe and affordable child care for America's working families, this program will support research, demonstration, and evaluation activities designed to provide a sound basis for policy development, consumer education, and innovation toward improved child care services and systems for the 21st century.

Rationale for the Budget Request

For FY 2004 the request level of \$9,864,000 is a \$136,000 reduction to the level of funding provided in the President's FY 2003 budget request. These funds will continue to support research, demonstration, and evaluation activities.

The appropriation for FY 2000 and the succeeding fiscal years provided the first source of funding in CCDF specifically for child care research. The appropriation requested for FY 2004 will continue to promote the generation of critically needed information about parents, children, and the child care market. This includes information such as the factors influencing parental choice; the cost, quality, and availability of child care in low-income communities; how work family and child care trends are changing; and the effects of policy alternatives.

Increasing our knowledge of what child care services and systems work best and disseminating that knowledge throughout the country are important steps in improving the quality of care provided to our children. Research and evaluation will provide information and data for policy makers to make decisions about how best to use resources and develop innovative child care strategies. In consultation with researchers, policy makers and practitioners, ACF developed a comprehensive research agenda to develop the capacity to support ongoing and future child care research while at the same time answering key questions for child care policy, planning, and program administration.

Resource and Program Data
Research and Evaluation Fund

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation	\$6,872,000	\$6,875,000	\$7,229,000
Demonstration/Development	3,100,000	3,125,000	2,635,000
Training/Technical Assistance			
Program Support			
Total, Resources	\$9,972,000	\$10,000,000	\$9,864,000
<u>Program Data:</u>			
Number of Grants	43	34	34
New Starts:			
#	13	9	9
\$	\$3,000,000	\$1,500,000	\$1,600,000
Continuations:			
#	32	25	25
\$	\$5,460,000	\$5,000,000	\$5,000,000
Contracts:			
#	3	3	3
\$	\$1,512,000	\$3,500,000	\$2,864,000
Interagency Agreements:			
#			2
\$			\$400,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Children and Families Services Programs

<u>FY 2004 Budget</u>	<u>Page</u>
Appropriation Language and Explanation of Language Changes	H-3
Amounts Available for Obligation	H-5
Summary of Changes	H-6
Budget Authority by Activity	H-8
Budget Authority by Object	H-11
Salaries and Expenses	H-13
Significant Items in House, Senate and Conference Appropriations Committee Reports	H-14
Authorizing Legislation	H-23
Appropriations History Table	H-31
Justification:	
General Statement	H-32
Head Start	H-34
Early Learning Opportunities Act Program	H-43
Consolidated Runaway and Homeless Youth Program	H-45
Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth	H-53
Child Abuse Programs	
Child Abuse State Grants	H-56
Child Abuse Discretionary Activities	H-61
Community-Based Family Resource and Support Grants	H-64
Child Welfare Programs	
Child Welfare Services	H-69
Child Welfare Training	H-74
Adoption Opportunities	H-76
Abandoned Infants Assistance Program	H-79
Adoption Incentives	H-82
Children's Health Act Programs	
Infant Adoption Awareness Program	H-87
Special Needs Adoption Awareness Campaign	H-89
Developmental Disabilities Programs	
State Councils	H-92
Protection and Advocacy	H-97
Projects of National Significance	H-101
University Centers for Excellence	H-104
Native American Programs	H-107

Social Services Research and Demonstration	H-111
Compassion Capital Fund	H-116
Promotion and Support of Responsible Fatherhood and Healthy Marriage.....	H-118
Community Services Programs	
Community Services Block Grant	H-121
Community Services Discretionary Activities.....	H-126
Community Economic Development.....	H-128
Rural Community Facilities	H-129
Job Opportunities for Low-Income Individuals.....	H-130
National Youth Sports.....	H-132
Community Food and Nutrition	H-134
Individual Development Accounts	H-139
Violent Crime Reduction Programs:	
Family Violence Prevention and Services/Battered Women's Shelters.....	H-142
Domestic Violence Hotline.....	H-148
Federal Administration	H-151
Detail of Full-Time Equivalent Employment.....	H-154
Detail of Positions	H-155

ADMINISTRATION FOR CHILDREN AND FAMILIES
Children and Families Services Programs

For carrying out, except as otherwise provided, the Runaway and Homeless Youth Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Head Start Act, the Child Abuse Prevention and Treatment Act, sections 310 and 316 of the Family Violence Prevention and Services Act, as amended, the Native American Programs Act of 1974, title II of Public Law 95-266 (adoption opportunities), the Adoption and Safe Families Act of 1997 (Public Law 105-89), sections 1201 and 1211 of the Children's Health Act of 2000, the Abandoned Infants Assistance Act of 1988, [the Early Learning Opportunities Act,] sections 413, 429A, 1110 and 1115 of the Social Security Act, and sections 40155, 40211, and 40241 of Public Law 103-322; for making payments under the Community Services Block Grant Act, section 473A of the Social Security Act, and title IV of Public Law 105-285, and for necessary administrative expenses to carry out said Acts and titles I, IV, X, XI, XIV, XVI, and XX of the Social Security Act, the Act of July 5, 1960 (24 U.S.C. ch. 9), the Omnibus Budget Reconciliation Act of 1981, title IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, section 5 of the Torture Victims Relief Act of 1998 (Public Law 105-320), sections 40155, 40211, and 40241 of Public Law 103-322, [sections 310 and 316 of the Family Violence Prevention and Services Act, as amended] and section 126 and titles IV and V of Public Law 100-485, [\$8,478,632,000] \$8,547,382,000 of which \$43,000,000, to remain available until September 30, [2004] 2005, shall be for grants to States for adoption incentive payments, as authorized by section 473A of title IV of the Social Security Act (42 U.S.C. 670-679) and may be made for adoptions completed [in fiscal years 2001 and 2002] before September 30, 2004; of which [\$640,325,000] \$552,312,000 shall be for making payments under the Community

Services Block Grant Act; and of which [\$6,667,533,000] \$6,815,570,000 shall be for making payments under the Head Start Act, of which \$1,400,000,000 shall become available October 1, [2003] 2004 and remain available through September 30, [2004] 2005: Provided , That to the extent Community Services Block Grant funds are distributed as grant funds by a State to an eligible entity as provided under the Act, and have not been expended by such entity, they shall remain with such entity for carryover into the next fiscal year for expenditure by such entity consistent with program purposes: [Provided further, That 88,133,000 shall be for the activities authorized the Runaway and Homeless Youth Act, of which \$39,739,900 is for the transitional living program.] *Provided further That all eligible entities currently in good standing in the Community Services Block Grant program shall receive an increase in funding proportionate to the increase provided in this Act for the Community Service Block Grant:* Provided further, That \$100,000,000 is for a compassion capital fund to provide grants to charitable organizations to emulate model social service programs and to encourage research on the best practices of social service organizations: Provided further, That the Secretary shall establish procedures regarding the disposition of intangible property which permits grant funds, or intangible assets acquired with funds authorized under section 680 of the Community Services Block Grant Act, as amended, to become the sole property of such grantees after a period of not more than 12 years after the end of the grant for purposes and uses consistent with the original grant: Provided further, That funds appropriated for section 680 (a)(2) of the Community Services Block Grant Act, as amended, shall be available for financing construction and rehabilitation and loans or investments in private business enterprises owned by community development corporations.

*Departments of Labor, Health and Human Services, Education and Related Agencies
Appropriations Act, 2003, as proposed in the FY 2003 President's Budget*

ADMINISTRATION FOR CHILDREN AND FAMILIES
Children and Families Services Programs

Amounts Available for Obligation¹

	<u>2002</u> <u>Enacted</u>	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>
Appropriation:			
Annual	\$8,429,183,000	\$8,509,454,000	\$8,577,382,000 ²
Advance funding of Head Start included in annual appropriation.....	[1,400,000,000]	[1,400,000,000]	[1,400,000,000]
Enacted rescission.....	-2,327,000	0	0
Subtotal, Adjusted Appropriation.....	\$8,426,856,000	\$8,509,454,000	\$8,577,382,000
Unobligated balance expiring.....	0	0	0
Unobligated balances available.....	0	0	0
Total, obligations	\$8,426,856,000	\$8,509,454,000	\$8,577,382,000

¹ Excludes the following amounts for reimbursements: FY 2002 \$14,461,000, FY 2003 \$14,461,000, FY 2004 \$14,461,000.

² This amount differs from the amount shown in the appropriation language because this amount includes legislative proposals supporting (1) a request of \$20,000,000 for the Promotion and Support of Responsible Fatherhood and Healthy Marriage Act; and (2) \$10,000,000 for Maternity Group Homes.

ADMINISTRATION FOR CHILDREN AND FAMILIES
Children and Families Services Programs

SUMMARY OF CHANGES

FY 2003 President's Budget Request	
Total estimated budget authority	\$8,509,454,000
FY 2004 Estimate	<u>\$8,577,382,000</u>
Net change	+\$67,928,000

	2003 President's Budget Base Budget (FTE) Authority	Change from Base Budget (FTE) Authority
Increases:		
A. Built-in:		
1) Increase in personnel compensation and related benefit costs associated with January 2004 civilian pay raise, annualization of FY 2003 pay raise, within grade increase, and one day extra pay in FY 2004.....		+\$6,028,000
2) To provide for inflationary cost increase.....		+\$381,000
Subtotal, Built-in Increases	\$8,509,454,000	+\$6,409,000
B. Program:		
1) Head Start base program increase...		+\$148,037,000
2) Domestic Violence Hotline program increase.....		+\$843,000
3) Increased funding for effort to identify and reduce erroneous payments.....		+\$5,000,000
4) Increased cost of implementing Unified Financial Management System.....		+\$1,000,000

2003 President's			
<u>Budget Base</u>		<u>Change from Base</u>	
	<u>Budget</u>		<u>Budget</u>
	<u>(FTE)</u>	<u>Authority</u>	<u>(FTE)</u>
			<u>Authority</u>
Subtotal, Program Increases			+\$154,880,000
Total Increases			+\$161,289,000
<u>Decreases:</u>			
A. <u>Built-in:</u>			
1) Reduction resulting from "right-sizing".....	1,512	-40	-\$4,141,000
2) Reduction in level of information technology support.....			-\$1,402,000
Subtotal, Built-in Decreases		-40	-\$5,543,000
B. <u>Program</u>			
1) Reduction in Community Services Block Grant Program.....			-\$75,000,000
2) Reduction in Rural Community Facilities Program.....			-\$6,161,000
3) Reduction in Community Food and Nutrition Program.....			-\$6,657,000
Subtotal, Program Decreases			-\$87,818,000
Total Decreases			-\$93,361,000
Net Change.....		-40	<u>+\$67,928,000</u>

ADMINISTRATION FOR CHILDREN AND FAMILIES
Children and Families Services Programs

Budget Authority by Activity

(Dollars in thousands)

	<u>2002</u>		<u>2003</u>		<u>2004</u>	
	<u>Enacted</u>		<u>President's</u>		<u>Estimate</u>	
	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>
Head Start		\$6,536,977		\$6,667,533		\$6,815,570
Early Learning Opportunities Act Program		24,997		0		0
Consolidated Runaway and Homeless Youth Program		88,024		88,133		88,043
Maternity Group Homes		0		10,000		10,000
Education and Prevention Grants to Prevent Sexual Abuse of Runaway, Homeless and Street Youth		14,999		14,999		14,999
Child Abuse State Grants		22,013		22,013		22,013
Child Abuse Discretionary Activities		26,081		26,351		26,301
Community-Based Family Resource and Support Grants		33,412		33,417		33,403
Child Welfare Services		291,986		291,986		291,986
Child Welfare Training		7,487		7,498		7,470
Adoption Opportunities		27,335		27,405		27,343
Abandoned Infants Assistance Program		12,194		12,205		12,086
Adoption Incentives		43,000		43,000		43,000

	<u>2002</u>		<u>2003</u>		<u>2004</u>	
	<u>Enacted</u>		<u>President's</u>		<u>Estimate</u>	
	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>
Children's Health Act Programs		12,906		12,906		12,906
Developmental Disabilities: State Councils		69,800		69,800		69,800
Developmental Disabilities: Protection and Advocacy		35,000		35,000		35,000
Developmental Disabilities: Projects of National Significance		11,684		11,734		11,642
Developmental Disabilities: Centers For Excellence		24,000		24,000		24,000
Native American Programs		45,826		45,196		45,119
Social Services Research and Demonstration		30,918		6,000		5,982
Compassion Capital Fund		29,949		100,000		100,000
Promotion and Support of Responsible Fatherhood and Healthy Marriage		0		20,000		20,000
Community Services Block Grant		649,967		570,000		494,964
Community Services Discretionary Activities		39,476		38,678		32,436
National Youth Sports		17,000		0		0
Community Food and Nutrition		7,312		6,657		0

	<u>2002</u>		<u>2003</u>		<u>2004</u>	
	<u>Enacted</u>		<u>President's</u>		<u>Estimate</u>	
	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>	<u>FTE</u>	<u>Amount</u>
Individual Development Accounts		24,943		24,990		24,912
Battered Women's Shelters and Domestic Violence Hotline		126,616		126,616		127,423
Federal Administration		171,466		171,837		179,584
Center for Faith-Based and Community Initiatives		1,497		1,500		1,400
Total, BA		\$8,426,856		\$8,509,454		\$8,577,382

ADMINISTRATION FOR CHILDREN AND FAMILIES
Children and Families Services Programs

Budget Authority by Object

	2003 President's Budget	2004 Estimate	Increase or Decrease
Full-time equivalent employment ceiling.....	1,512	1,472	-40
Full-time equivalent of overtime and holiday hours.....	0	0	0

Average SES salary.....	\$133,638	\$137,293	+\$3,655
Average GS grade.....	12.5	12.5	+0
Average GS salary.....	\$64,350	\$66,054	+\$1,466

Personnel Compensation:

Full-time permanent (11.1).....	111,733,000	113,531,000	0+1,798,000
Other than full-time permanent (11.3).....	1,973,000	2,002,000	+29,000
Other personnel compensation (11.5).....	1,291,000	1,186,000	-105,000
Subtotal, Personnel compensation (11.9)...	114,997,000	116,719,000	+1,722,000
Civilian Personnel benefits (12.1).....	21,708,000	22,041,000	+333,000
Subtotal, Pay Costs.....	136,705,000	138,760,000	+2,055,000

Travel and transportation of persons (21.0).....	3,782,000	3,832,000	+50,000
Transportation of things (22.0).....	70,000	71,000	+1,000
Rental payments to GSA (23.1).....	14,978,000	17,449,000	+2,471,000
Communications, utilities and miscellaneous (23.3).....	3,138,000	3,187,000	+49,000
Printing and reproduction (24.0).....	1,487,000	1,491,000	+4,000

Other contractual services:

Advisory and assistance services (25.1)...			
Other services (25.2).....	4,241,000	7,377,000	+3,136,000
Purchases of goods and services from government accounts (25.3).....	29,709,000	28,953,000	-756,000
Operation and maintenance of facilities (25.4).....	1,047,000	1,001,000	-46,000
Medical care (25.6).....	8,000	8,000	0
Operation and maintenance of equipment (25.7).....	186,000	189,000	+3,000
Subtotal, Other contractual services.....	138,603,000	142,783,000	+4,180,000

	2003 President's <u>Budget</u>	2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Supplies and materials (26.0).....	769,000	779,000	+10,000
Equipment (31.0).....	629,000	538,000	-91,000
Grants, subsidies, and contributions (41.0).....	8,209,292,000	8,268,491,000	+59,199,000
Insurance claims and indemnities (42.0).....	1,000	1,000	0
Subtotal, Non-Pay Costs.....	8,372,749,000	8,438,622,000	+65,873,000
Total, BA by Object Class.....	\$8,509,454,000	\$8,577,382,000	+\$67,928,000

ADMINISTRATION FOR CHILDREN AND FAMILIES
Children and Families Services Programs

Salaries and Expenses

(Budget Authority)

	2003 President's <u>Budget</u>	2004 <u>Estimate</u>	Increase or <u>Decrease</u>
<u>Personnel Compensation:</u>			
Full-time permanent (11.1).....	111,733,000	113,531,000	+1,798,000
Other than full-time permanent (11.3).....	1,973,000	2,002,000	+29,000
Other personnel compensation (11.5).....	1,291,000	1,186,000	-105,000
Subtotal, Personnel compensation (11.9)	114,997,000	116,719,000	+1,722,000
Civilian Personnel benefits (12.1).....	21,708,000	22,041,000	+333,000
Subtotal, Pay Costs.....	136,705,000	138,760,000	+2,055,000
Travel and transportation of persons (21.0)	3,782,000	3,832,000	+50,000
Transportation of things (22.0).....	70,000	71,000	+1,000
Communications, utilities and miscellaneous (23.3).....	3,138,000	3,187,000	+49,000
Printing and reproduction (24.0).....	1,487,000	1,491,000	+4,000
<u>Other contractual services:</u>			
Advisory and assistance services (25.1)...	103,412,000	105,255,000	+1,843,000
Other services (25.2).....	4,241,000	7,377,000	+3,136,000
Purchases of goods and services from government accounts (25.3).....	29,709,000	28,953,000	-756,000
Operation and maintenance of facilities (25.4).....	1,047,000	1,001,000	-46,000
Medical care (25.6).....	8,000	8,000	0
Operation and maintenance of equipment (25.7).....	186,000	189,000	+3,000
Subtotal, Other contractual services	138,603,000	142,783,000	+4,180,000
Supplies (26.0).....	769,000	779,000	+10,000
Subtotal, Non-Pay Costs.....	\$147,849,000	\$152,143,000	+4,294,000
Total, Salaries and Expenses.....	\$284,554,000	\$290,903,000	+\$6,349,000

ADMINISTRATION FOR CHILDREN AND FAMILIES

Children and Families Services Programs

SIGNIFICANT ITEMS IN HOUSE, SENATE AND CONFERENCE
APPROPRIATIONS COMMITTEE REPORTS

The following section represents FY 2003 Congressional requirements for reports and significant items derived from Senate Report 107-216 (Labor, Health and Human Services and Education). These actions discussed below are contingent on inclusion of similar language and funding in the final FY 2003 appropriation and related reports. Additional items may be transmitted at a later date as a result of the final Conference report.

2003 Senate Committee Report LanguageItem

[National Impact Study of Head Start] -- However, the Committee is concerned that the congressionally-mandated National Impact Study of Head Start has not been completed and encourages the ACF to move forward and complete this important study. The National Impact Study was mandated by Congress to be completed by 2003.

Action Taken or to be Taken

The Department will continue to move forward to complete the National Impact Study as soon as possible, consistent with all the requirements enumerated in Section 649 of the Head Start Act.

Item

[Early Head Start programs in rural areas] -- The Committee is aware of the unique circumstances rural areas face in designing Early Head Start programs to meet the needs of families. Rural areas experience higher costs per child, either due to the higher cost of transporting infants and children to Early Head Start Centers, or because of higher rents due to the lack of adequate and licensable facilities in rural areas. In selecting new grantees under this program, the Committee believes the Department should give consideration to applicants serving rural areas that meet or exceed all performance criteria even though they may propose a higher cost per child due to these factors.

Action Taken or to be Taken

The Department will assure that, should funds be appropriated which permit an Early Head Start expansion, there will be an equitable distribution of these funds between

rural and non-rural areas and will further assure that no rural program or rural funding applicant is disqualified from funding consideration solely because of cost factors related to the rural nature of the program.

Item

[Qualifications of Head Start teachers] -- The Committee strongly supports the effort to strengthen the qualifications of Head Start teachers. At least 50 percent of teachers in center-based Head Start programs must have an associate, baccalaureate, or advanced degree in early childhood education or a degree in a related field, with experience in teaching preschool children, by September 30, 2003. The Committee expects the Department to focus staff development efforts on increasing the educational level of Head Start teachers in order to meet this goal.

Action Taken or to be Taken

The Department will continue its efforts, initiated in FY 1999, to increase the number of Head Start teachers with qualifying degrees. The Department is pleased to advise the Committee that in FY 2002, 51 percent of Head Start teachers had a qualifying degree, thus meeting the statutory mandate.

Item

[Expansion of existing preschool programs to serve infants and toddlers] -- The Committee encourages the Department of Health and Human Services to support efforts by local Head Start programs to use grant funds to deliver quality services to the infant and toddler population where a community assessment evidences a need for such services and the local program has the capacity to meet that need. The Committee supports this expansion in response to changing local community needs, separate and apart from the new grant process under the Early Head Start program created as part of the 1994 Head Start reauthorization. When combined with the new grant authority for Early Head Start which flows from increased appropriations annually, expansion of existing preschool programs to serve infants and toddlers is particularly responsive to research emphasizing the developmental needs of our youngest children—needs which can be ably addressed through the Head Start model of comprehensive services.

Action Taken or to be Taken

The Department is sensitive to the needs of infant and toddler age children and their families. However, the Department is also concerned about the many Head Start eligible children of pre-school age who are not currently served by the program. The Department, therefore, believes that the specific set-asides in the Head Start Act regarding Early Head Start must determine the level of services provided to infant and toddler age children.

Item

[Nutritional and physical activity component within Head Start] -- Therefore, the Committee urges the Head Start Bureau to review the scope of good nutrition and physical activities which are presently being undertaken in response to the Head Start Performance Standards, as well as the current knowledge base on good nutrition and physical activities for young children. Further, the Committee urges the Head Start Bureau to review the activities presently being undertaken by local programs to promote healthy bodies as a prerequisite for strong minds and to identify best practices currently employed by local programs. As a follow up, the Committee encourages the Head Start Bureau, in collaboration with the National Head Start Association, to devise a plan for implementing a locally-determined but coordinated effort to achieve the goals of a stronger, more vibrant and effective nutritional and physical activity component within Head Start programs. The Committee expects that the Head Start Bureau will enter into a cooperative agreement with the National Head Start Association to carry out these activities.

Action Taken or to be Taken

The Department is committed to assuring that local Head Start programs are providing appropriate physical activities and nutrition education to Head Start children. The Department will review current practices in this area and implement any necessary changes, working with other interested parties, as appropriate.

Item

[Personal Responsibility and Work Opportunities Act] -- The Senate is currently considering the reauthorization of the Personal Responsibility and Work Opportunities Act, in order to assist individuals to secure gainful employment and help families to gain self-sufficiency in the new economy. As a result of the 1996 enactment of welfare reform, families previously eligible for Head Start services based on their low-income status have found themselves marginally exceeding those income limitations and, therefore, losing access to Head Start services for their children. The Committee recognizes that Head Start does not serve all income-eligible children and their families in the country. Nonetheless, while eligibility for other programs is sensitive to regional disparities in income, Head Start eligibility is not. It is clear that an inner-city family's expenses with respect to food, housing and medical needs are different from those of a rural family, while a rural family's transportation needs, for one, may well outpace similar needs for their urban neighbors. Eligibility requirements should reflect this difference. Current law gives the Secretary of Health and Human Services authority to permit the enrollment of a "reasonable number" of over-income families in Head Start. In a welfare-reformed era, families may find their income marginally exceeding national poverty guidelines, while their need for quality early childhood programming is even more pronounced. The Committee encourages the Secretary to permit local programs to best address local community needs in these changing times, but encourages flexibility which does

not deny services to the neediest of the needy. The Committee encourages the Secretary to exercise his authority, as appropriate, to permit the enrollment of over-income children and their families in up to 25 percent of program placements, so long as services are not denied to income-eligible children and families as a result of this flexibility.

Action Taken or to be Taken

The Department appreciates the Committee's concerns about providing grantees increased flexibility in selecting needy families to be served by Head Start. However, the Department is reluctant at this point in time to revise Head Start eligibility standards given that there are many children eligible for Head Start, using current eligibility requirements, that are not now being served.

Item

[Migrant Head Start programs] -- The Committee is aware that the Department's "Descriptive Study of Seasonal Farmworker Families" published in September 2001 revealed that just 19 percent of eligible children of migrant and seasonal farmworkers are served by Migrant Head Start programs. The study also concluded "that Migrant Head Start agencies greatly improve the lives of migrant and seasonal farmworker families, and in doing so, help to strengthen local agricultural economies." The Committee urges the Head Start Bureau to provide an increase in funding for Migrant Head Start programs proportionate to the overall increase in the Head Start appropriation.

Action Taken or to be Taken

The Department will continue to assure that Migrant Head Start programs will receive their full and fair share of all Head Start funding, including any increases that may be appropriated.

Item

[Pre-literacy training and technical assistance for Head Start grantees] -- The Committee encourages the Department to ensure that in securing pre-literacy training and technical assistance for Head Start grantees, every reasonable effort is made to use competitive procedures in securing private sector service providers to assist in completing the Head Start mission.

Action Taken or to be Taken

The Department will assure that any future assistance necessary to provide literacy training to Head Start grantees will be procured in an appropriate manner.

Item***[Social competence and school readiness upon completion of Head Start program]***

-- The Committee is aware that the goal of the Head Start program is to ensure the social competence and school readiness of children upon completion of the program. The Committee expects the Department to continue to promote learning and brain development to accelerate and improve the cognitive development of Head Start children. The Committee expects the Department to monitor Head Start programs to ensure that a majority of children participating in Head Start programs meet the minimum educational performance measures and standards upon completion of the program as outlined in the Head Start Act, as amended in 1998.

Action Taken or to be Taken

The Department will continue efforts to improve the cognitive development of Head Start children. All Head Start programs monitored this year will be evaluated against all relevant statutory and regulatory requirements.

Item

[TCU/Head Start partnership] -- The TCU/Head Start partnership has made a lasting investment in our Indian communities by creating associate degree programs in Early Childhood Development and related fields. New graduates of these programs can help meet the Congressional mandate that 50 percent of all program teachers earn an Associate Degree in Early Childhood Development or a related discipline by 2003. One clear impediment to the on-going success of this partnership program is the decrease in discretionary funding being targeted for the TCU/Head Start partnership. The Committee urges the Head Start Bureau to direct sufficient funding to allow current grantees to extend their programs for two additional years and to ensure that this vital program can continue and be expanded to serve all tribal college communities.

Action Taken or to be Taken

The Department appreciates the work done by Tribal Colleges in training Head Start staff and intends to provide continued funding for this effort in FY 2003.

Item

[TLP grantees] -- It is the Committee's expectation that current and future TLP grantees will continue to provide transitional living opportunities and supports the pregnant and parenting homeless youth, as is their current practice. To further ensure that pregnant and parenting homeless youth are able to access transitional living opportunities and supports in their communities, the Committee encourages the Secretary, acting through the network of Federally-funded runaway and homeless youth training and technical assistance providers, to offer guidance to grantees and others on the programmatic modifications required to address

the unique needs of pregnant and parenting youth and on the various sources of funding available for residential services to this population.

Action Taken or to be Taken

In December, the annual Training and Technical Assistance Providers meeting primarily focused on the provision of training and technical assistance to those transitional living programs with a special emphasis on serving pregnant and parenting homeless youth. Sessions included presentations from experts in the subject matter and offered the training and technical assistance providers with an opportunity to brainstorm on how best to deliver the appropriate training and support to the grantees. The training and technical assistance providers are expected to provide the Family and Youth Services Bureau (FYSB) with a concrete plan for the delivery of services to the grantees serving the pregnant and parenting homeless youth population in the second quarter of the fiscal year.

The training and technical assistance providers will also work closely with the FYSB funded National Clearinghouse on Families and Youth to identify potential funding sources for those TLP programs serving pregnant and parenting homeless youth. This collaboration will help to identify funding at the Federal, State and local governmental levels as well as through foundations with an interest in funding pregnant and parenting homeless teen programs.

Item

[TLP grantees] -- The Committee expects the Family and Youth Services Bureau to continue to provide the technical assistance needed to enable TLP grantees and their community partners to address the unique needs of young mothers and their children, as well as helping interested entities in identifying sources of funding currently available to provide residential services to this population.

Action Taken or to be Taken

The training and technical assistance providers will work closely with the FYSB funded National Clearinghouse on Families and Youth to identify potential funding sources for those TLP programs serving young mothers and their children as well as other interested entities. This collaboration will help to identify potential funding sources at the Federal, State and local governmental levels as well as through foundations with an interest in funding programs serving young mothers and their children.

Item

[Native American Languages program] -- The Committee continues its significant interest in the revitalization of native languages through education. The Committee encourages ANA to allocate additional resources to support the Native American Languages program and urges the ANA to make schools a part of this effort, consistent with the policy expressed in the Native American Languages Act. (Page 192)

Action taken or to be taken

In FY 2002, ANA's Native Language program expended \$9,157,885 in grant awards to ensure the survival and continuing vitality of native languages. The assistance reflects new awards funded at a total of \$5,014,207 and continuation projects at \$4,143,678.

Item

[Rural Comprehensive Community Development Technical Assistance program] -- The Committee has provided bill language that instructs the Office of Community Services (OCS) to work with statewide associations of Community Action Agencies and individual Community Action Agencies that have experience in serving rural populations to implement a Rural Comprehensive Community Development Technical Assistance program in the States of West Virginia, Ohio, Kentucky, Iowa, Michigan, Wisconsin and Indiana. The Committee recognizes that there is an established network serving these particular States that is uniquely qualified to meet the needs of rural communities. As additional funds become available, the Office of Community Services is urged to consider the economic development technical assistance needs of rural communities in other States. The Committee recommendation includes \$2,500,000 for OCS to carry out this program.

Action Taken or to be Taken

The Office of Community Services administers programs which are aimed at addressing the economic development technical assistance needs of rural communities, including the Community Services Block Grant, and the Department will comply with any related language in the enacted appropriation.

Item

[Self-sufficiency strategies] -- The Committee understands that the Department of Health and Human Services, and its Office of Community Services in particular, could better use this network in developing future policy initiatives. The Committee notes that in a number of States, including Iowa and Pennsylvania, CAA-initiated family development and self-sufficiency programs are an integral component of welfare reform efforts. The Administration is encouraged to look for further nationwide linkages between those individuals seeking to leave the welfare system and become self-sufficient and the many family development and self-sufficiency strategies operated by Community Action Agencies.

Action Taken or to be Taken

The Department is exploring comprehensive human service delivery strategies -- focusing on a diverse mix of community organizations, as exemplified by State Community Action Agencies, and faith-based organizations that understand the need for a comprehensive approach to the delivery of human services.

Item

[CSBG funds] – In addition, the Committee believes that the Office of Community Services should be more aggressive in ensuring proper oversight of some State CSBG State expenditure of CSBG allocations that are intended to fund local eligible activities. The Committee expects the Office of Community Services to better evaluate and enforce each State's expenditure of CSBG funds. The Committee is also concerned that some State audits of the previous years' expenditures of CSBG funds are not adequately reviewed and acted upon.

Action Taken or to be Taken

The Office of Community Services (OCS) conducts investigations on several States in each fiscal year to evaluate compliance with the program assurances in their annual State plans. The investigations do not presently address the fiscal controls and fund accountability systems. OCS will, on a sample basis, expand its investigations to include a review of the State's fiscal control and fund accounting system during the investigations. Additionally, we will add a special section to the A-133 Compliance Audit Guide Supplement to include an examination of the fiscal controls and fund accounting procedures relating to disbursement of the 90 percent allotted to eligible entities when the single state audit is conducted.

Item

[Funding to States] – The Committee expects the Office of Community Services to release funding to the States in the most timely manner. The Committee also expects the States to make funds available promptly. The Committee is aware that the Office of Community Services and some States have been extraordinarily delinquent in providing funds to local eligible entities.

Action Taken or to be Taken

The OCS will work more diligently with all parties within the Department to ensure timely availability of funds to the States.

Item

[Job Creation Demonstration] – As in the past, the Committee expects that a priority for grants under this program go to experienced community development corporations.

Action Taken or to be Taken

OCS reserves the largest share of its funding for experienced Community Development Corporations (CDCs). It places priority on using operational funding for experienced CDCs in order to increase the prospects of success and to provide for effective use of federal funding. In addition, OCS has developed different priority areas that allow for less experienced community development corporations to build capacity and experience by

entering into a cooperative agreement and providing incremental funding for the project. This approach assures that the corporation garners the expertise necessary to warrant full funding and receives appropriate technical assistance.

Item

[Emergency preparation for small communities] -- The Committee is concerned that many small and very small community water and wastewater treatment systems might be most vulnerable to terrorist attack, yet least prepared to deal with the issue. The Committee urges OCS to support a RCAP Small Community Infrastructure Safety and Security Training and Technical Assistance project, which will provide State, regional and national infrastructure safety and security training workshops and on-site technical assistance targeted to small and very small community water and wastewater treatment systems. The goal of the project is to improve the capacity of small systems to better prepare for emergencies, develop emergency preparedness training manuals for small water systems, identify appropriate technologies to secure such systems, and provide technical assistance to small communities struggling to deal with these issues.

Action Taken or to be Taken

Both urban and suburban low-income communities have similar issues of appropriate levels of preparedness to address safety of the physical infrastructure and readiness of the residents to be a part of the solution in response to a safety crisis. To meet the objective of the congressional language, OCS will seek to fund an initiative that addresses the universal need of low-income communities to be better prepared to respond to a crisis affecting the safety of that community.

Item

[Technical Assistance Centers for Children and Families initiative] -- In establishing its Technical Assistance Centers for Children and Families initiative, the Committee urges the Administration to give consideration to establishing a Pacific Basin focus given the unique needs, geographical isolation, cultural complexities, and Federal responsibilities for the residents of that region.

Action Taken or to be Taken

The Department is sensitive to the need to ensure that technical assistance provided to the Pacific Basin area is focused on enhancing the local capacity of those jurisdictions.

ADMINISTRATION FOR CHILDREN AND FAMILIES
Children and Families Services Programs

Authorizing Legislation¹

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Estimate
1. Head Start [Section 639 of the Head Start Act, as amended]	Such sums	\$6,667,533,000	Such sums**	\$6,815,570,000
2. Head Start Transition Grants [Section 639b(1)]	(Not less than the amount obligated for FY 1998)	(35,000,000)	(Not less than the amount obligated for FY 1998)	(35,000,000)
3. Indian and Migrant Program [Section 640(a)(2)(A)]	(Not less than the amount obligated for FY 1998)	(448,454,000)	(Not less than the amount obligated for FY 1998)	(458,321,000)
4. Training and Technical Assistance [Section 640(a)(2)(C)]	(Not less than 2% of appropriation) \$3M to Family Literacy program	(136,350,660)	(Not less than 1% of appropriation) \$3M to Family Literacy program	(71,155,700)
5. Collaboration grants [Section 640(a)(5) (A)]	Such sums	(8,175,000)	Such sums	(8,175,000)
6. Infants and Toddlers Program [Section 640(a)(6)]	(10 % of amount appropriated)	(666,753,300)	(10 % of amount appropriated)	(681,557,000)

¹ Authorizations expiring in FY 2003 in this chart are shown with an asterisk (*) and in FY 2004 with a double asterisk (**).

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Estimate
7. Quality Improvement [Section 640(a)(3) (A)(i)]	(25 % of amount exceeding previous year's adjusted appropriation)	0	(25% of amount exceeding previous year's adjusted appropriation)	0
8. Head Start Fellowships [Section 640(a)(2)(D)] [Section 648A(d) (6)]	1,000,000	(1,000,000)	1,000,000	(1,000,000)
9. Head Start Research, Demonstration, Evaluation [Section 640(a)(2)(E)] [Section 639(b)(3)]	Such sums	(20,000,000)	Such sums	(20,000,000)
10. Impact research [Section 639(b)(2)]	No more than 5,000,000	(5,000,000)	No more than 5,000,000	(5,000,000)
11. Runaway and Homeless Youth Program [Section 388(a)(1) of the Runaway and Homeless Youth Act, as amended]	Such sums	48,393,100	Such sums**	61,630,000
12. Maternity Group Homes [Proposed legislation]	Such sums	10,000,000	Such sums	10,000,000

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Estimate
13. Runaway and Homeless Youth Transitional Living Programs [Section 388(a)(2) of the Runaway and Homeless Youth Act, as amended]	(Not less than 20% of and not more than 30% of runaway appropriation)	39,739,900	Such sums**	26,413,000
14. Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless Street Youth [Section 388 of Part E of the Runaway and Homeless Youth Act]	Such sums	14,999,000	Such sums**	14,999,000
15. Child Abuse State Grants [Section 112 of the Child Abuse Prevention and Treatment Act]	Such sums	22,013,000	Such sums	22,013,000
16. Child Abuse Discretionary Activities [Section 112 of the Child Abuse Prevention and Treatment Act, as amended]	(40% of which is available for demonstrations)	26,351,000	Such sums	26,301,000

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Estimate
17. Community-Based Family Resource and Support Grants [Section 210 of the Child Abuse Prevention and Treatment Act, as amended]	Such sums	33,417,000	Such sums	33,403,000
18. Child Welfare Services [Section 420 of the Social Security Act, as amended]	325,000,000	291,986,000	325,000,000	291,986,000
19. Child Welfare Training [Section 426 of the SSA]	Such sums	7,498,000	Such sums	7,470,000
20. Adoption Opportunities [Section 205 of the Child Abuse Prevention and Treatment and Adoption Reform Act]	27,405,000	27,405,000	Such sums	27,343,000
21. Abandoned Infants Assistance [Section 104(a)(1) of the Abandoned Infants Assistance Act, of 1988 as amended]	Such sums	12,205,000	Such sums	12,086,000
22. Adoption Incentives [Section 473 A of Social Security Act]	20,000,000	43,000,000	Such sums**	43,000,000

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Estimate
23. Children's Health Activities [Section 330 F & G of title III of the Public Health Service Act]	Such sums	12,906,000	Such sums	12,906,000
24. State Councils [Section 129 (b) of the Developmental Disabilities Assistance and Bill of Rights Act, as amended]	Such sums	69,800,000	Such sums	69,800,000
25. Protection and Advocacy [Section 145 of the Developmental Disabilities Assistance and Bill of Rights Act, as amended]	Such sums	35,000,000	Such sums	35,000,000
26. Projects of National Significance [Section 163 of the Developmental Disabilities Assistance and Bill of Rights Act, as amended]	Such sums	11,734,000	Such sums	11,642,000
27. Centers for Excellence [Section 156 of the Developmental Disabilities Assistance and Bill of Rights Act, as amended]	Such sums	24,000,000	Such sums	24,000,000

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Estimate
28. Programs for Native Americans [Section 816 (a) of the Native American Programs Act of 1974, as amended]	Such sums*	45,196,000	Such sums	45,119,000
29. Social Services Research and Demonstration [Section 1110 of the Social Security Act, as amended]	Such sums	6,000,000	Such sums	5,982,000
30. Compassion Capital Fund [Section 1110 of the Social Security Act, as amended]	Such sums	100,000,000	Such sums	100,000,000
31. Promotion and Support of Responsible Fatherhood and Healthy Marriage [Proposed legislation]	64,000,000	20,000,000	Such sums	20,000,000
32. Community Services Block Grant [Section 674 (a) Community Services Block Grant Act, as amended]	Such sums	570,000,000	Such sums**	494,964,000

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Estimate
33. Community Services Discretionary Activities [Section 674(b)(3) of the Community Services Block Grant Act, as amended]	Not more than 9% of section 674(a)	38,678,000	Not more than 9% of section 674(a) **	32,436,000
34. Individual Development Accounts [Section 416 of the Assets for Independence Act]	25,000,000	24,990,000	25,000,000**	24,912,000
35. Battered Women's Shelters [Section 310 of the Family Violence Prevention Act]	Such sums	124,459,000	Such sums	124,423,000
36. Domestic Violence Hotline [Section 316 F of the Family Violence Prevention Act]	Such sums	2,157,000	Such sums	2,157,000
37. Federal Administration	Such sums	173,337,000	Such sums	180,984,000
Unfunded Authorizations:				
1. National Youth Sports [Section 682(g) of the Community Services Block Grant Act, as amended]	15,000,000	0	15,000,000	0

	2003 Amount Authorized	2003 President's Budget	2004 Amount Authorized	2004 Estimate
2. Community Food and Nutrition [Section 681(d) of the Community Services Block Grant Act, as amended]	Such sums	6,657,000	Such sums**	0
3. Rural Community Facilities Program (Section 680 of the Community Services Block Grant Act, as amended]	Such sums	(6,161,000)	Such sums**	0
4. Native American Environmental Quality [Section 816 (c) of the Native American Programs Act, as amended]	Such sums	0	Such sums	0
5. Native American Language Grants [Section 816 (e) of Native American Programs Act, as amended]	Such sums	0	Such sums	0
Total request level		\$8,509,454,000		\$8,577,382,000
Total request level against definite authorizations		\$379,976,000		\$379,898,000

ADMINISTRATION FOR CHILDREN AND FAMILIES
Children and Families Services Programs

APPROPRIATIONS HISTORY TABLE

<u>Year</u>	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1995	\$5,051,476,000	\$4,169,806,000	\$4,296,796,000	\$4,205,297,000
Rescission				1,811,757
Supplemental	13,000,000			
1996	4,878,625,000	4,862,286,000	4,877,550,000	4,849,730,000
Rescission				628,887
1997	5,234,257,263	4,544,643,000	4,560,652,000	4,765,969,428
Rescission				508,000
1998	5,251,298,000	4,856,435,000	4,779,434,000	5,363,061,000
1999	5,498,900,000	5,598,052,000	5,611,094,000	5,676,058,614
2000	5,944,100,000	5,946,820,683	6,113,784,000	6,032,087,000
Rescission				6,142,000
2001	6,587,953,000	6,135,216,000	6,684,635,000	7,956,354,000
Rescission				506,000
2002	8,181,492,000	8,275,442,000	8,592,496,000	8,429,183,000
Rescission				2,327,000
2003	8,509,454,000			
2004	8,577,382,000			

Justification

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Budget Authority	\$8,426,856,000	\$8,509,454,000	\$8,577,382,000	+\$67,928,000
FTE	1,465	1,512	1,472	-40

General Statement

The FY 2004 request for Children and Families Services Programs is \$8,577,382,000, an increase of \$67,928,000 over the 2003 President's Budget request. This budget would support 1,472 FTE in FY 2004, 40 FTE below the FY 2003 President's Budget request.

This budget reflects the Administration's commitment to a balanced fiscal framework that puts discretionary spending on a more reasonable and sustainable growth path, while focusing new resources on innovative solutions for meeting the challenges that face the nation. ACF continues to use strategic management of human and real capital to accomplish the President's management priorities, such as identifying activities and services that could more efficiently be achieved using outsourcing services; targeting improvements in the financial management performance arena, including participation in the Department's unified systems integration project; and directing resources to better manage our e-government activities and expand the e-government services we provide to our clients.

The budget continues support for Presidential initiatives identified in FY 2003 and maintains a strong commitment to important ongoing programs to help improve the quality of life of American's families and children. Highlights of our FY 2004 request for Children and Families Services Programs include:

- **Head Start (+\$148 million):** The budget request for FY 2004 is \$6,815,570,000, an increase of \$148 million over the FY 2003 President's budget request. This increase, coupled with a reallocation of resources through legislative changes proposed as part of the Head Start reauthorization, will be used to maintain current service levels and to increase the Head Start children enrollment.
- **Domestic Violence Hotline (+\$843,000):** The FY 2004 request for the Domestic Violence Hotline is \$3,000,000, an increase of \$843,000 over the FY 2003 President's Budget. The increase addresses the need to answer more calls as well as to position the Hotline to properly respond to the "spike" in calls as various broadcast and public awareness activities impact their call numbers. The Hotline averages 300 to 400 calls a day; a response to a public

awareness message or a program that publicizes the Hotline number will provide a "spike" of 400 to 500 calls within hours.

- **Community Services Block Grant and Community Services Discretionary Programs (-\$88 million):** The budget request reflects a lack of strong performance data for the Community Services Block Grant program. The proposed reauthorization legislation includes measures that would generate more consistent performance data in future years for this program, and also ensure more accountability. Under this legislative proposal, non-performing grantees would lose their designation and be subject to a state-run award competition. In addition, funding is not requested for the Community Food and Nutrition Program (-\$6.7 million) and the Rural Community Facilities Program (-\$6.2 million) since these programs duplicate services provided by other programs.

HEAD START

Authorizing Legislation – Legislation will be proposed to reauthorize section 639 of the Head Start Act.

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Current Funding	\$5,136,977,000	\$5,267,533,000	\$5,415,570,000	+\$148,037,000
Advance Funding	1,400,000,000	1,400,000,000	1,400,000,000	0
Total, BA	\$6,536,977,000	\$6,667,533,000	\$6,815,570,000	+\$148,037,000

FY 2004 Authorization....\$6,815,570,000 (as proposed in the reauthorization request).

Purpose and Method of Operation

Head Start provides grants to local public and private non-profit and for-profit agencies to provide comprehensive child development services to children and families. Intended primarily for preschoolers from low-income families, Head Start promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services. Head Start programs emphasize cognitive, language and socio-emotional development to enable each child to develop and function at his or her highest potential. Head Start children receive comprehensive health services, including immunizations, physical and dental exams and treatment, and nutritional services. At least ten percent of the enrollment opportunities in each program must be made available to children with disabilities. Head Start engages parents in their children's learning and helps them in making progress toward their educational, literacy and employment goals. The Head Start program also emphasizes significant involvement of parents in the administration of local Head Start programs.

In FY 1995, the Early Head Start program was established in recognition of the mounting evidence that the earliest years, from birth to three years of age, matter a great deal to children's growth and development. In FY 2002, the Administration awarded Early Head Start grants to approximately 775 projects, which served more than 62,000 children under the age of three. In FY 2003 and FY 2004, it is estimated that this enrollment level will stay approximately the same.

Many Head Start programs provide part-day, center-based services or home-based services for eight or nine months a year. However, grantees have the option of providing full-day, full-year services and, in recent years, an increased number of grantees have been offering this option, often through collaborations with local child care providers to help meet the child care needs of parents who are either working or in job training.

Head Start grantees are funded through one of ten Regional Offices of the Administration for Children and Families (ACF) or through the American Indian/Alaskan Native and Migrant/Seasonal Program Branches located in Washington, D.C. Regional Offices have responsibility for reviewing and approving grantee funding requests and for ensuring that grantees are operating high quality programs, consistent with the requirements of all relevant laws and regulations. This is accomplished, among other ways, by on-site monitoring of all grantees at least once every three years. The Head Start Bureau (HSB), located in the Administration on Children, Youth and Families -- part of ACF -- provides support to the Regional Offices and to the grantees in the areas of budget, policy, training and technical assistance, information dissemination, and others.

Over the past two years there have been increased efforts to help Head Start programs enhance school readiness and the development of early literacy skills. In April 2002, the President announced his *Good Start/Grow Smart* initiative which is designed to assure that every Head Start teacher has the training and skills necessary to provide Head Start children the early literacy, language, and numeracy skills they will need to be successful in school. Intensive training of Head Start teachers began in the summer of 2002 and we will continue to support these efforts through FY 2003 and in FY 2004.

Related to this initiative in FY 2004 there will be increased efforts made to assure that Head Start programs are achieving their primary purpose of promoting school readiness -- that all children leave Head Start with the cognitive, emotional and social skills they need to be successful in school. Particular emphasis will be placed on both child and family literacy so that Head Start children can better develop the skills they need to become lifelong readers and parents can better develop the skills they need both to improve their own lives and to help their children become reading proficient. In FY 2004 Head Start will be investing considerable resources in early literacy, including:

- developing research-based training materials that can be shared with Head Start grantees;
- funding research efforts designed to identify the most effective early literacy curricula and teaching strategies for Head Start children; and
- targeting T/TA resources to assure that every Head Start classroom is delivering training that promotes reading, vocabulary, language, and numeracy skills.

In addition, we also will continue efforts initiated in FY 2002 to develop a process to help Head Start programs determine the degree to which each child is benefiting from their time in Head Start. This new outcomes-based accountability system is being field tested during the 2002-2003 academic year with implementation scheduled for the fall of 2003.

Funding for the Head Start program during the last five years has been as follows:

1999	\$4,658,151,448
2000	\$5,266,210,858
Advance appropriation available FY 2001	[\$1,400,000,000]

2001	\$4,799,123,000
Advance appropriation available FY 2002	[\$1,400,000,000]
2002	\$5,136,570,000
Advance appropriation available FY 2003	[\$1,400,000,000]
2003	\$5,267,533,000
Advance appropriation available FY 2004	[\$1,400,000,000]

Rationale for the Budget Request

The budget proposes to reauthorize the Head Start program in FY 2004 at a funding level of \$6,815,570,000, an increase of \$148 million over the FY 2003 President's Budget. This increase, coupled with proposed legislation to better target funds, will be used to maintain current service levels and to increase Head Start enrollment.

Specifically, Head Start programs will be given an increase in their FY 2003 funding level of approximately 2.2 percent to offset inflationary increases and maintain competitive salaries for teachers. In addition, we will increase enrollment by approximately 10,500 children in those areas of the country with the greatest unmet need for Head Start services. This will include areas which have seen recent demographic changes that have resulted in significant increases in the number of low-income families; areas in remote parts of the country where there are few, if any, alternative services providers and areas with large numbers of unserved but eligible children.

As part of the Head Start reauthorization we are proposing to strengthen the program by eliminating some of the extremely prescriptive provisions that have been added to the statute over the years in order to provide greater flexibility to target the dollars where they are needed most. Of particular note, we are proposing to change the current statutory set-aside for training and technical assistance (T/TA) from at least two percent of the total appropriation to up to two percent of the total appropriation. This will afford the Secretary with more discretionary authority to allocate these resources each year in a manner that would maximize benefits to children and families. In FY 2004, we would use this new flexibility to serve more children.

Providing the Secretary with greater discretionary authority over the use of Head Start resources is being proposed because a better balance is needed in the use of Head Start's resources than is possible with the current T/TA set-aside. T/TA resources have grown considerably in recent years. Since FY 1990, for example, the Head Start T/TA budget mandated by law has increased by more than 300 percent while during that same time period Head Start enrollment has increased by only 58 percent and the number of Head Start grantees has increased only slightly. Moreover, considerable investments have been made in Head Start training using resources apart from the T/TA set-aside. Grantees have received significant amounts of quality improvement funds over the last decade, which have been used, in part, to provide training to classroom and other staff. In fact, the Head Start Act requires that the training of classroom and other staff be a priority use of the quality improvement funds. In short, the mandated T/TA budget has increased well above the rate of growth in Head Start while at the same time grantees have had access to quality improvement funds which provide them yet additional T/TA resources. This statutory change will allow the Secretary to determine the appropriate level of funding for T/TA each year taking into account all the other needs of the program and the children and families served.

In addition to the proposed statutory change in the training and technical assistance setaside, we will be submitting a more comprehensive package of legislative proposals to be included as part of the Head Start reauthorization. The focus of these changes will be on strengthening our ability to ensure quality and accountability in the Head Start program in order to address the President's commitment to enhancing school readiness for all children.

Head Start also will continue to fund two comprehensive evaluation efforts designed to measure Head Start's overall effectiveness -- the Family and Children Experiences Survey (FACES) and the National Impact Study. FACES is designed to: (1) learn more about the families that Head Start serves; (2) find out how well Head Start programs are performing; (3) find ways in which program performance can be improved; and (4) provide information that can help guide policy decisions and guidelines that will assist individual programs and centers. A national sample of children will be assessed before and after their Head Start experience. Head Start program staff will be interviewed and observed, particularly in the classroom during their interactions with Head Start children. In the next few years, a detailed body of knowledge will be developed which will assure that all Head Start programs have the ability to deliver high quality responsive services which ensure children enter school ready and eager to learn and that there will be positive, long lasting effects on the lives of the children and families served by Head Start.

The National Head Start Impact Study, which began in FY 2001, is designed to provide a national analysis of the impact of Head Start on the development and school-readiness of low-income children. Based on both the requirements of the Head Start Act and the recommendations of an advisory panel of national experts, this longitudinal study utilizes a rigorous experimental design involving the random assignment of children to Head Start and non-Head Start groups. Data collection for the main study began in the Fall of 2002. This funding request will support the third year of data collection activities that will follow children as they move from Head Start into kindergarten and first grade.

A PART assessment was conducted for this program and helped inform the FY 2004 budget policy. A summary of the PART assessment follows on the next page.

Program: Head Start

Agency: Department of Health and Human Services
Bureau: Administration for Children and Families



☐ Results Achieved
☒ Results Not Demonstrated

☐ Measures Adequate
☒ New Measures Needed

Key Performance Measures

	Year	Target	Actual
Long-term Measure: Gain in word knowledge measured at Head Start entry and exit (for 2000 measure, measured at school entry points -- 12 child pts = 34%, after 2002 as % gain)	2000		10
	2002	32%	32%
	2003	32%	
	2004	34%	
Annual Measure: Percentage of parents that report reading to their child three times a week or more	2000		60%
	2002	70%	70%
	2003	70%	
	2004	70%	
Annual Measure: Other annual measures under development			

Rating: Results Not Demonstrated**Program Type: Competitive Grants****Program Summary:**

Head Start provides grants to local public, non-profit and for-profit programs to help low-income children prepare for school and improve their overall development.

The assessment found:

1. The program's long-term goals are not well linked to its purpose — providing comprehensive development services to children and families. President Bush has focused on strengthening Head Start in its traditional mission of promoting school readiness. The current program design is flawed because it does not hold individual grantees responsible for effectively preparing children for school.
2. The program's existing long-term goals are weak in the area of promoting school readiness.
3. Head Start has not demonstrated sufficient progress in achieving short and long-term results. While Head Start children demonstrate gains in vocabulary, math and social skills, relative to their non-Head Start socio-economic peers, they still lag behind other children. Head Start is not well coordinated with other early education and care programs.

Based on these findings the Department will:

1. Create a new system to assess every Head Start center on its success in preparing children for school.
2. Propose legislation to better integrate Head Start, child care and state operated pre-school programs.
3. Develop annual performance measures that assess the progress of individual grantees in improving school readiness and better measure the impact on children.
4. Provide inflationary increase in program funding for 2004.

(For more information on this program, please see the Department of Health and Human Services chapter in the Budget volume.)

Program Funding Level (in millions of dollars)

2002 Actual	2003 Estimate	2004 Estimate
6,537	6,668	6,816

Resource and Program Data
Head Start Program

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$6,326,314,750	\$6,453,616,000	\$6,666,107,000
(Head Start)	5,705,340,600	5,820,200,000	6,018,628,000
(Early Head Start)	620,974,150	633,416,000	647,479,000
Research, Demonstration & Evaluation	20,000,000	20,000,000	20,000,000
Training/Technical Assistance	166,414,250	169,688,000	105,234,000
(Head Start)	133,731,400	136,350,000	71,156,000
(Early Head Start)	32,682,850	33,338,000	34,078,000
Monitoring/Panel Review	23,841,000	24,229,000	24,229,000
TOTAL PROGRAM	\$6,536,570,000	\$6,667,533,000	\$6,815,570,000
Program Data:			
Number of Applicants			
Number of Grants	1,620	1,640	1,650
New Starts:			
#	39	40	30
\$	\$17,325,000	\$36,200,000	\$6,200,000
Continuations:			
#	1,581	1,600	1,620
\$	\$6,440,276,953	\$6,568,860,000	\$6,746,897,000
Contracts:			
#	40	35	35
\$	\$76,743,047	\$60,248,000	\$60,248,000
Interagency Agreements:			
#	3	3	3
\$	\$2,225,000	\$2,225,000	\$2,225,000

Resource and Program Data
Additional Head Start Program Data

	2002 Actual	2003 President's Budget	2004 Estimate
Number of Grants	1,570	1,570	1,570
Children in Head Start Projects:			
(Head Start)	912,345	912,345	922,833
(Early Head Start)	850,119	850,119	860,607
	62,226	62,226	62,226
Average ACYF Cost Per Child			
(Head Start)	\$6,934	\$7,074	\$7,224
(Early Head Start)	\$6,711	\$6,846	\$6,993
	\$9,979	\$10,179	\$10,405
Number of Staff	198,000	198,000	200,000
Volunteers	1,450,000	1,450,000	1,470,000
Number of Classrooms	49,800	49,800	50,400

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Head Start (CFDA # 93.600)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$100,154,494	\$102,170,000	\$104,418,000	\$2,248,000
Alaska	12,104,386	12,348,000	12,620,000	272,000
Arizona	96,912,656	98,863,000	101,038,000	2,175,000
Arkansas	61,023,626	62,252,000	63,622,000	1,370,000
California	801,429,541	817,556,000	835,551,000	17,995,000
Colorado	65,716,131	67,038,000	68,513,000	1,475,000
Connecticut	49,984,520	50,990,000	52,112,000	1,122,000
Delaware	12,286,428	12,534,000	12,810,000	276,000
District of Columbia	24,090,814	24,576,000	25,117,000	541,000
Florida	252,369,803	257,448,000	263,112,000	5,664,000
Georgia	161,740,120	164,995,000	168,625,000	3,630,000
Hawaii	21,977,038	22,419,000	22,912,000	493,000
Idaho	21,662,707	22,099,000	22,585,000	486,000
Illinois	259,780,216	265,008,000	270,838,000	5,830,000
Indiana	88,666,972	90,451,000	92,441,000	1,990,000
Iowa	49,494,840	50,491,000	51,602,000	1,111,000
Kansas	47,909,093	48,873,000	49,948,000	1,075,000
Kentucky	103,472,617	105,555,000	107,877,000	2,322,000
Louisiana	135,048,223	137,766,000	140,797,000	3,031,000
Maine	26,661,319	27,198,000	27,796,000	598,000
Maryland	74,928,894	76,437,000	78,119,000	1,682,000
Massachusetts	104,182,066	106,278,000	108,616,000	2,338,000
Michigan	225,290,497	229,824,000	234,880,000	5,056,000
Minnesota	69,643,329	71,045,000	72,608,000	1,563,000
Mississippi	155,259,338	158,384,000	161,868,000	3,484,000
Missouri	113,255,841	115,535,000	118,077,000	2,542,000
Montana	20,117,436	20,522,000	20,973,000	451,000
Nebraska	34,580,417	35,276,000	36,052,000	776,000
Nevada	19,785,629	20,184,000	20,628,000	444,000
New Hampshire	12,860,678	13,119,000	13,408,000	289,000
New Jersey	125,175,590	127,694,000	130,503,000	2,809,000
New Mexico	49,185,413	50,175,000	51,279,000	1,104,000
New York	418,238,532	426,655,000	436,041,000	9,386,000
North Carolina	132,667,143	135,337,000	138,314,000	2,977,000
North Dakota	16,036,018	16,359,000	16,719,000	360,000

STATE/TERRITORY	2002 Actual	2003 President's Budget	2004 Estimate	Difference +/- 2003
Ohio	236,999,439	241,768,000	247,087,000	5,319,000
Oklahoma	76,909,804	78,457,000	80,183,000	1,726,000
Oregon	57,105,005	58,254,000	59,536,000	1,282,000
Pennsylvania	219,114,506	223,524,000	228,442,000	4,918,000
Rhode Island	21,184,290	21,611,000	22,086,000	475,000
South Carolina	78,506,579	80,086,000	81,848,000	1,762,000
South Dakota	18,078,512	18,442,000	18,848,000	406,000
Tennessee	112,343,511	114,604,000	117,125,000	2,521,000
Texas	454,292,444	463,434,000	473,630,000	10,196,000
Utah	36,270,290	37,000,000	37,814,000	814,000
Vermont	13,022,989	13,285,000	13,577,000	292,000
Virginia	95,366,343	97,285,000	99,425,000	2,140,000
Washington	97,246,982	99,204,000	101,386,000	2,182,000
West Virginia	48,624,566	49,603,000	50,694,000	1,091,000
Wisconsin	86,940,813	88,690,000	90,641,000	1,951,000
Wyoming	11,882,457	12,122,000	12,389,000	267,000
Subtotal	5,627,580,895	5,740,823,000	5,867,130,000	126,307,000
American Indian Program	181,794,159	185,452,000	189,532,000	4,080,000
Migrant Program	257,814,769	263,002,000	268,789,000	5,787,000
Outer Pacific	14,942,945	15,244,000	15,579,000	335,000
Puerto Rico	234,303,518	239,018,000	244,276,000	5,258,000
Virgin Islands	9,878,464	10,077,000	10,299,000	222,000
Subtotal	698,733,855	712,793,000	728,475,000	15,682,000
Total States/Territories	6,326,314,750	6,453,616,000	6,595,605,000	141,989,000
Unallocated Expansion Funding	0	0	70,502,000	70,502,000
Technical Assistance	166,414,250	169,688,000	105,234,000	-64,454,000
RD&E	20,000,000	20,000,000	20,000,000	0
Monitoring	23,841,000	24,229,000	24,229,000	0
Subtotal Adjustments	210,255,250	213,917,000	149,463,000	-64,454,000
TOTAL RESOURCES	\$6,536,570,000	\$6,667,533,000	\$6,815,570,000	\$148,037,000

EARLY LEARNING OPPORTUNITIES ACT PROGRAM

Authorizing Legislation -- Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2001, as enacted by Section 1(a)(1) P.L. 106-554.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$24,988,000	\$0	\$0	\$0

FY 2004 Authorization....Such sums.

Purpose and Method of Operation

In FY 2002, 31 grants were made to local community councils composed of representatives from agencies involved in early learning programs, parent organizations and key community leaders. The grants support programs that help parents, caregivers, child care providers and educators increase their capacity to facilitate development of cognitive skills, language comprehension, expressive language, social-emotional and motor skills, and promote learning readiness. These grants also promote effective parenting; enhance early childhood literacy; develop linkages among early learning programs within a community and between early learning programs and health care services for young children. They increase access to early learning opportunities for young children with special needs (including developmental delays). The ELOA grants increase access to existing early learning programs by expanding days or times young children are served, by expanding the number served, or by improving the affordability of the programs for low-income families. Some grantees will improve the quality of early learning programs through professional development and training, increased compensation, and recruitment and retention incentives for early learning providers; and remove barriers to early learning (e.g., transportation difficulties and needs for services in nontraditional hours). Grants range from \$441,000 to \$1,000,000 and last 17 months in duration.

Rationale for the Budget Request

No funds are being requested in FY 2004 for the Early Learning Opportunities Program. The FY 2003 President's Budget request proposes to fund similar activities in the Department of Education through the Early Reading First program and the Early Childhood Education Professional Development Grant.

Resource and Program Data
Early Learning Opportunities Act Program

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary ¹	\$24,238,360		
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support ²	749,640		
Total, Resources	\$24,988,000		
<u>Program Data:</u>			
Number of Grants			
New Starts:			
#	31		
\$	\$24,238,360		
Continuations:			
#			
\$			
Contracts:			
#	1		
\$	\$513,448		
Interagency Agreements:			
#	2		
\$	\$432,000		

¹ Includes funds for discretionary grants and panel review of grants in the making of the awards.

² Includes funds for information technology support, technical assistance, salaries/benefits and associated overhead.

CONSOLIDATED RUNAWAY AND HOMELESS YOUTH PROGRAM

Authorizing Legislation – Legislation will be proposed to reauthorize section 388(a)(1) of the Runaway and Homeless Youth Act.

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Basic Centers	\$48,288,000	\$48,393,100	\$61,630,000	+\$13,236,900
Transitional Living	39,736,000	39,739,900	26,413,000	-13,326,900
Maternity Group Homes	0	10,000,000	10,000,000	0
Total, BA	\$88,024,000	\$98,133,000	\$98,043,000	-\$90,000

FY 2004 Authorization....\$98,043,000 (as proposed in the reauthorization request).

Purpose and Method of Operation

The Runaway and Homeless Youth Program provides grants to local public and private organizations to establish and operate local runaway and homeless youth shelters consistent with the Administration for Children and Families' goals of improving the well-being of youth and improving services provided to youth and their families. The shelters address the crisis needs of runaway and homeless youth and their families. Grants are used to develop or strengthen community-based shelters that are not a part of the law enforcement, juvenile justice, child welfare or mental health systems.

Under Part A, the Basic Center Program (BCP) awards grants to community-based public and private agencies for the provision of outreach, crisis intervention, temporary shelter, counseling, family unification and aftercare services to runaway and homeless youth and their families. Funds available for the Basic Center Programs are allotted among the States using a formula based on the population of youth under age 18 as a proportion of the national population under age 18.

Under Part B, the Transitional Living Program (TLP) provides grants to public and private organizations to support projects that provide longer-term residential services for up to 18 months to homeless youth ages 16-21. These services include counseling in basic life skills, interpersonal skill building, educational advancement, job attainment skills, and physical and mental health care. These services are designed to help youth that are homeless make a successful transition to self-sufficient living and assist young mothers in moving forward with their lives by providing support so they can finish school, acquire job skills and learn to be good parents.

Transitional Living Program grantees are required to provide youth with stable, safe living accommodations and services that help them develop the skills necessary to move to independence. Living accommodations may be host family homes, group homes, or "supervised apartments." (Supervised apartments are either agency-owned apartment buildings or "scattered site" apartments, which are single-occupancy apartments rented directly by young people with support from the agency.) These community-based, adults-supervised group homes will provide safe, stable, nurturing environments for mothers who cannot live safely with their own families.

The Maternity Group Homes Program helps protect and support some of the most vulnerable of America's families and the vital role they play in the nation's future. The need is especially great for young pregnant mothers and their children who lack safe and stable environments in which to live. These women are vulnerable to abuse and neglect and often end up on welfare, in foster care, in homeless shelters, or on the streets and sadly, their children are at high risk of being teen parents themselves. To break this cycle of abuse and poverty, funds will be targeted for community-based, adult-supervised group homes for young mothers and their children.

Approximately 10 percent of the funds from the Consolidated Runaway and Homeless Youth Program in each of the past five years have been used to fund projects that support and strengthen the work of the shelters. These include the national toll-free runaway and homeless youth crisis hotline; training and technical assistance activities; Runaway and Homeless Youth Management Information System (RHYMIS-LITE); demonstration projects on a wide variety of topics identified in the legislation; and initiatives to improve program administration, outreach, and prevention activities among local shelters.

Funding for the Runaway and Homeless Youth program during the last five years has been as follows:

1999	\$58,558,344
2000	\$64,144,778
2001	\$69,122,871
2002	\$88,022,850
2003	\$98,133,000

Rationale for the Budget Request

The Administration proposes to reauthorize the Runaway and Homeless Youth Program at a funding level of \$98,043,000. The proposed reauthorization improves the program by providing funding preference to grantees that serve up to 20 youth at a time and protects the youth we serve. It is estimated that between 500,000 and 1.5 million young people run away from home each year. The size of the homeless youth population has been estimated to be approximately 300,000 young people each year (Institute for Health Policy Studies, 1995).

The change in funding levels for the Basic Centers and Transitional Living Programs between FYs 2003-2004 is a result of the fact that the allocation between the two program had been

changed through appropriation language, which had increased funding for the Transitional Living Program above the formula split in authorizing language. For FY 2004, we will propose reinstatement of the allocation formula in the current authorizing statute.

- The Basic Center amount of \$61,630,000 will be used for approximately 231 new starts and 219 continuation applicants.
- The Transitional Living amount of \$26,413,000 will be used to fund approximately 42 new starts and 103 continuation applicants.
- The Maternity Group Homes amount of \$10,000,000 will fund approximately 53 continuation applicants. These funds will provide young pregnant and parenting women with access to community-based maternity group homes through the use of targeted grants to local community or faith-based organizations. Grantees will be providing a range of coordinated services such as child care, education, job training, counseling and advice on parenting and life skills to young mothers. Funding for these maternity group homes will provide pregnant and parenting homeless youth access to transitional living opportunities, an alternative to the environments of violence and despair which many young pregnant mothers face and secure brighter futures for their children.
- Runaway and Homeless Youth funding will continue to support a 24-hour National Runaway Crisis Hotline Service, a training and technical assistance network and other program supports. The crisis hotline responds to approximately 120,000 calls a year. Of these calls, 46 percent come from youth, 31 percent come from parents and the remaining 33 percent are general information and client-related calls.

Resource and Program Data
Basic Centers Program

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$43,078,680	\$43,553,800	\$55,460,690
Research/Evaluation	150,000	175,000	175,000
Demonstration/Development	1,320,000	1,320,000	1,320,000
Training/Technical Assistance	1,115,000	1,000,000	1,500,000
Program Support ¹	2,624,320	2,344,300	3,174,310
Total, Resources	\$48,288,000	\$48,393,100	\$61,630,000
Program Data:			
Number of Grants	378	368	450
New Starts:			
#	111	105	231
\$	\$13,802,733	\$14,635,871	\$32,328,815
Continuations:			
#	267	263	219
\$	\$31,860,947	\$31,412,929	\$26,126,875
Contracts:			
#	5	5	5
\$	\$2,624,320	\$2,344,300	\$3,174,310
Interagency Agreements:			
#			
\$			

¹ Includes funding to support contracts for Runaway and Homeless Youth Information System (RHYMIS), National Clearinghouse for Youth (NCFY), logistical contract, grants review/paneling cost and information technology support for the program.

Resource and Program Data
Transitional Living Program

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$37,921,040	\$37,095,910	\$23,771,700
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	1,494,129	2,000,000	1,783,310
Program Support ¹	320,731	643,990	857,990
Total, Resources	\$39,735,900	\$39,739,900	\$26,413,000
Program Data:			
Number of Grants	207	220	145
New Starts:			
#	97	97	42
\$	\$20,258,999	\$17,740,114	\$7,689,633
Continuations:			
#	110	123	103
\$	\$19,156,180	\$21,355,796	\$17,865,377
Contracts:			
#	3	3	3
\$	\$320,721	\$643,990	\$857,990
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support, printing and grants/panel review costs.

Resource and Program Data
Maternity Group Homes

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary		\$9,000,000	\$9,000,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance		500,000	500,000
Program Support ¹		500,000	500,000
Total, Resources		\$10,000,000	\$10,000,000
Program Data:			
Number of Grants		53	53
New Starts:			
#		53	
\$		\$9,500,000	
Continuations:			
#			53
\$			\$9,500,000
Contracts:			
#		1	1
\$		\$500,000	\$500,000
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support, printing and grants/panel review costs.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Runaway and Homeless Youth - Basic Center (CFDA #93.623)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$476,067	\$653,305	\$859,798	\$206,493
Alaska	271,935	271,935	271,935	0
Arizona	767,471	783,966	1,017,063	233,097
Arkansas	306,419	409,694	544,725	135,031
California	5,681,522	5,444,122	6,746,512	1,302,390
Colorado	896,169	609,751	730,245	120,494
Connecticut	530,249	479,090	628,932	149,842
Delaware	118,929	113,239	149,290	36,051
District of Columbia	112,500	100,000	100,000	0
Florida	2,502,161	2,134,131	2,778,435	644,304
Georgia	1,298,137	1,263,057	1,629,393	366,336
Hawaii	161,995	174,214	223,048	48,834
Idaho	209,507	217,768	283,163	65,395
Illinois	1,721,441	1,872,809	2,443,666	570,857
Indiana	1,071,202	914,627	1,200,067	285,440
Iowa	438,178	435,537	572,708	137,171
Kansas	445,876	418,115	545,970	127,855
Kentucky	535,000	566,198	759,118	192,920
Louisiana	841,489	687,859	966,990	279,131
Maine	178,034	182,925	237,081	54,156
Maryland	396,700	783,966	1,020,439	236,473
Massachusetts	836,681	897,573	1,144,256	246,683
Michigan	2,006,924	1,524,379	1,980,958	456,579
Minnesota	1,165,582	965,272	989,706	24,434
Mississippi	447,299	435,537	598,927	163,390
Missouri	721,106	827,520	1,096,286	268,766
Montana	138,016	139,371	181,394	42,023
Nebraska	358,484	293,009	346,800	53,791
Nevada	272,474	291,809	372,228	80,419
New Hampshire	180,579	187,280	260,413	73,133
New Jersey	1,161,221	1,219,503	1,540,476	320,973
New Mexico	370,071	300,520	388,836	88,316
New York	3,772,664	3,198,884	3,511,611	312,727
North Carolina	1,161,645	1,132,396	1,480,954	348,558
North Dakota	102,500	102,500	102,500	0

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	1,776,480	1,698,594	2,203,744	505,150
Oklahoma	775,690	643,907	685,855	41,948
Oregon	763,074	479,090	645,624	166,534
Pennsylvania	1,627,533	1,742,148	2,276,953	534,805
Rhode Island	135,666	148,082	143,871	-4,211
South Carolina	178,906	566,198	780,033	213,835
South Dakota	95,000	121,950	131,722	9,772
Tennessee	533,981	783,966	1,062,149	278,183
Texas	4,024,671	3,397,188	4,354,904	957,716
Utah	415,000	415,000	515,000	100,000
Vermont	199,992	100,000	137,980	37,980
Virginia	877,272	1,001,735	1,320,894	319,159
Washington	1,175,383	871,074	1,153,988	282,914
West Virginia	246,172	246,172	316,016	69,844
Wisconsin	813,855	783,966	1,065,374	281,408
Wyoming	118,000	118,000	118,000	0
Subtotal	45,412,902	43,148,931	54,616,030	11,467,099
American Samoa	45,000	45,000	45,000	0
Guam	45,000	45,000	45,000	0
Northern Mariana Islands	0	45,000	45,000	0
Puerto Rico	344,149	415,118	727,760	312,642
Virgin Islands	0	45,000	45,000	0
Subtotal	434,149	595,118	907,760	312,642
Total States/Territories	45,847,051	43,744,049	55,523,790	11,779,741
Technical Assistance	1,115,000	1,000,000	1,500,000	500,000
Other	1,325,949	3,649,051	4,606,210	957,159
Subtotal Adjustments	2,440,949	4,649,051	6,106,210	1,457,159
TOTAL RESOURCES	\$48,288,000	\$48,393,100	\$61,630,000	\$13,236,900

**EDUCATION AND PREVENTION GRANTS TO REDUCE SEXUAL ABUSE OF
RUNAWAY, HOMELESS AND STREET YOUTH**

Authorizing Legislation -- Legislation will be proposed to reauthorize section 388 of Part E of the Runaway and Homeless Youth Act.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$14,999,000	\$14,999,000	\$14,999,000	\$0

FY 2004 Authorization...\$14,999,000 (as proposed in the reauthorization request).

Purpose and Method of Operation

The Runaway and Homeless Youth Act provides grants to private, non-profit agencies for street-based outreach and education, including treatment, counseling, provision of information, and referral for runaway, homeless and street youth who have been subjected to or are at risk of being subjected to sexual abuse. The goal of these efforts is to help youth leave the streets. Many of the street youth served through the program are running from or have been asked to leave homes characterized by abuse, neglect, or parental drug or alcohol abuse. Once on the streets, such youth are at risk of being sexually exploited or abused by adults for pleasure or profit. The street outreach program provides critical resources to help these vulnerable young people.

This street outreach program for runaway, homeless and street youth is a lifeline to youth living on the streets and at risk for sexual abuse and exploitation. Due to the transient and sometimes anonymous characteristics of such youth, who often avoid contact with service providers until trust has been established, little is known about the unduplicated numbers served by FYSB grantees.

Funding for the program during the last five years has been as follows:

1999	\$14,973,286
2000	\$14,996,610
2001	\$14,999,000
2002	\$14,999,000
2003	\$14,999,000

Rationale for the Budget Request

The FY 2004 President's budget proposes to reauthorize the Education and Prevention Grants to Reduce Sexual Abuse program for five years without changes at a funding level of \$14,999,000, the same as the FY 2003 President's Budget.

The Education and Prevention Grants to Reduce Sexual Abuse Program will fund 48 new starts and 97 continuation applicants. These funds will provide outreach services to runaway and homeless youth who have been sexually abused and/or who are particularly vulnerable to being subjected to sexual abuse while on the streets. These services will be coordinated with existing services for runaway and homeless youth, namely emergency shelter and transitional living program efforts. The coordination of these resources and programs will increase the capacity of service providers to provide outreach to street youth.

Resource and Program Data
Education & Prevention Grants to Reduce Sexual Abuse of
Runaway, Homeless, and Street Youth

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary	\$13,499,100	\$13,499,100	\$13,499,100
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	1,000,000	1,000,000	1,000,000
Program Support ¹	499,900	499,900	499,900
Total, Resources	\$14,999,000	\$14,999,000	\$14,999,000
<u>Program Data:</u>			
Number of Grants	149	142	145
New Starts:			
#		91	48
\$		\$8,866,907	\$4,656,074
Continuations:			
#	149	51	97
\$	\$14,499,100	\$5,632,193	\$9,843,026
Contracts:			
#	1	1	1
\$	\$499,900	\$499,900	\$499,900
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support, printing and grant/paneling review cost.

CHILD ABUSE STATE GRANTS

Authorizing Legislation – Legislation to reauthorize section 112 of the Child Abuse Prevention and Treatment Act is pending Congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$22,013,000	\$22,013,000	\$22,013,000	\$0

FY 2004 Authorization....Such sums (as requested in pending FY 2002 straight-line reauthorization).

Purpose and Method of Operation

The Child Abuse and Neglect State Grant program provides grants to States to improve child protective service systems. Grants are based on a flat rate of \$50,000 per State. Additional funds are distributed in proportion to the state's population of children under the age of 18. This program serves as a catalyst to assist States in improving: intake, assessment, screening and investigation of child abuse and neglect reports; risk and safety assessment protocols; training for child protective services workers and mandated reporters; the establishment of programs and procedures for the identification, prevention and treatment of child abuse and neglect; and services to disabled infants with life-threatening conditions and their families.

Funding for the Child Abuse State Grant program during the last five years has been as follows:

1999	\$21,026,000
2000	\$21,022,650
2001	\$21,026,000
2002	\$22,013,000
2003	\$22,013,000

Rationale for the Budget Request

The FY 2004 request for the Child Abuse State Grants is \$22,013,000, the same as the FY 2003 President's Budget. Current research and data collection efforts indicate continuing high numbers of child abuse and neglect reports and similar severity in outcomes and forms of maltreatment. Over 900,000 children were victims of substantiated or indicted abuse or neglect in 2000. This number reflects incidents that have been reported to, investigated and confirmed by child protective services agencies.

Continued support for this program will help States improve their response to child abuse and neglect by strengthening child protective service systems, resulting in improved safety outcomes

for children. Along with other funds for child welfare, such as the title IV-B Child Welfare Services program, this program will assist States in strengthening investigation, assessment and treatment procedures, to protect children who have come to the attention of child welfare agencies from suffering further abuse. These funds will also support activities and services to help decrease the percentage of children with substantiated reports of maltreatment who have a repeat substantiated report of maltreatment within 6 months from eight percent in 1999 to seven percent in 2004.

Resource and Program Data
Child Abuse State Grants

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$22,013,000	\$22,013,000	\$22,013,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$22,013,000	\$22,013,000	\$22,013,000
<u>Program Data:</u>			
Number of Grants	57	57	57
New Starts:			
#	57	57	57
\$	\$22,013,000	\$22,013,000	\$22,013,000
Continuations:			
#			
\$			
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Child Abuse and Neglect State Grants (CFDA #93.669)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$364,402	\$343,640	\$343,640	\$0
Alaska	103,374	99,850	99,850	0
Arizona	432,554	407,293	407,293	0
Arkansas	240,409	227,835	227,835	0
California	2,638,665	2,467,723	2,467,723	0
Colorado	358,069	337,726	337,726	0
Connecticut	285,555	270,001	270,001	0
Delaware	104,457	100,861	100,861	0
District of Columbia	82,182	80,057	80,057	0
Florida	1,070,468	1,003,081	1,003,081	0
Georgia	657,084	616,995	616,995	0
Hawaii	132,774	127,308	127,308	0
Idaho	153,277	146,457	146,457	0
Illinois	958,275	898,297	898,297	0
Indiana	0	461,516	461,516	0
Iowa	255,317	241,759	241,759	0
Kansas	249,539	236,362	236,362	0
Kentucky	328,411	310,026	310,026	0
Louisiana	391,374	368,831	368,831	0
Maine	134,305	128,738	128,738	0
Maryland	429,539	404,477	404,477	0
Massachusetts	469,809	442,087	442,087	0
Michigan	776,454	728,482	728,482	0
Minnesota	410,151	386,369	386,369	0
Mississippi	266,945	252,619	252,619	0
Missouri	449,555	423,171	423,171	0
Montana	114,385	110,134	110,134	0
Nebraska	176,005	167,684	167,684	0
Nevada	193,233	183,774	183,774	0
New Hampshire	136,634	130,913	130,913	0
New Jersey	634,226	595,647	595,647	0
New Mexico	192,330	182,931	182,931	0
New York	1,362,577	1,275,902	1,275,902	0
North Carolina	599,660	563,363	563,363	0
North Dakota	95,015	92,043	92,043	0

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	858,333	804,955	804,955	0
Oklahoma	299,737	283,245	283,245	0
Oregon	286,909	271,265	271,265	0
Pennsylvania	0	813,811	813,811	0
Rhode Island	119,356	114,776	114,776	0
South Carolina	332,559	313,900	313,900	0
South Dakota	106,714	102,968	102,968	0
Tennessee	441,391	415,546	415,546	0
Texas	1,697,474	1,588,683	1,588,683	0
Utah	251,135	237,854	237,854	0
Vermont	91,286	88,560	88,560	0
Virginia	536,471	504,347	504,347	0
Washington	473,665	445,689	445,689	0
West Virginia	162,614	155,178	155,178	0
Wisconsin	433,061	407,766	407,766	0
Wyoming	86,067	83,685	83,685	0
Subtotal	21,423,781	21,446,180	21,446,180	0
American Samoa	56,157	55,750	55,750	0
Guam	63,713	62,808	62,808	0
Northern Mariana Islands	53,358	53,157	53,157	0
Puerto Rico	355,636	335,454	335,454	0
Virgin Islands	60,355	59,671	59,671	0
Subtotal	589,219	566,840	566,840	0
Total States/Territories	22,013,000	22,013,020	22,013,020	0
TOTAL RESOURCES	\$22,013,000	\$22,013,020	\$22,013,020	\$0

CHILD ABUSE DISCRETIONARY ACTIVITIES

Authorizing Legislation – Legislation to reauthorize section 112 of the Child Abuse Prevention and Treatment Act is pending Congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$26,081,000	\$26,351,000	\$26,301,000	-\$50,000

FY 2004 Authorization....Such sums (as requested in pending FY 2002 straight-line reauthorization).

Purpose and Method of Operation

The Child Abuse Discretionary Activities account funds a number of research and demonstration grants and contracts. The program funds research on the causes, prevention, identification and treatment of child abuse and neglect; investigative, administrative and judicial procedures; and the national incidence study of child abuse and neglect. The program also funds projects to: compile, publish and disseminate training materials; provide technical assistance; and demonstrate and evaluate improved methods and procedures to prevent and treat child abuse and neglect. In addition, the program funds a resource center on issues relating to child maltreatment and the National Clearinghouse on Child Abuse and Neglect Information. The Clearinghouse gathers and disseminates information on promising programs of prevention and treatment and on the incidence of child abuse and neglect. Demonstration projects funded under this program have revealed some promising practices including findings about service provision to chronically neglectful families, as well as information which shows that community-based groups for adolescent mothers can be successful in helping mothers considered at high risk of neglecting their children (ages 0 to 4) to be more stable and reliable in their interactions with their children and engage in pre-school readiness type activities (e.g., learning numbers and colors).

Research and demonstration grants are awarded competitively to public and private nonprofit agencies, including State and local government agencies, universities, voluntary and faith-based organizations. Contracts may be awarded to nonprofit or proprietary organizations. Projects supported by grants and contracts awarded under this program may run up to five years, depending upon the availability of funds.

Funding for the Child Abuse Discretionary Activities during the last five years has been as follows:

1999	\$14,140,013
2000	\$18,025,128
2001	\$33,204,000
2002	\$26,081,000

2003 \$26,351,000

Rationale for the Budget Request

The FY 2004 request for Child Abuse Discretionary Activities is \$26,301,000, which is \$50,000 less than the FY 2003 President's Budget. Funds from the Child Abuse Discretionary Activities are used to conduct activities designed to assist and enhance national, State and community efforts to prevent, identify, and treat child abuse and neglect.

Resource and Program Data
Child Abuse Discretionary Activities

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary ¹	\$7,330,000		
Research/Evaluation	5,992,787	9,261,357	9,261,357
Demonstration/Development	4,881,386	8,503,300	8,503,300
Training/Technical Assistance	7,481,836	7,886,343	7,886,343
Program Support ²	394,179	700,000	650,000
Total, Resources	\$26,080,188	\$26,351,000	\$26,301,000
<u>Program Data:</u>			
Number of Grants	57	53	43
New Starts:			
#	17	20	
\$	\$7,330,000	\$6,699,329	
Continuations:			
#	40	33	43
\$	\$11,970,694	\$11,077,827	\$14,707,539
Contracts:			
#	17	18	12
\$	\$4,935,523	\$5,973,844	\$8,993,461
Interagency Agreements:			
#	6	6	6
\$	\$1,843,971	\$2,600,000	\$2,600,000

¹ This amount represents Congressionally funded earmarks.

² Includes funding for information technology support and grant/paneling review.

COMMUNITY-BASED FAMILY RESOURCE AND SUPPORT GRANTS

Authorizing Legislation – Legislation to reauthorize section 210 of the Child Abuse Prevention and Treatment Act is pending Congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$33,412,000	\$33,417,000	\$33,403,000	-\$14,000

FY 2004 Authorization....Such sums (as requested in pending FY 2002 straight-line reauthorization).

Purpose and Method of Operation

The purposes of the Community-Based Family Resource and Support Grants program are: (1) to assist each State in developing, operating, expanding and enhancing a network of community-based, prevention-focused, family resource and support programs that coordinate resources among a broad range of human service organizations within the State; and (2) to foster an understanding, appreciation, and knowledge of diverse populations in order to be effective in preventing and treating child abuse and neglect.

Seventy percent of a State's grant amount is calculated on the basis of the number of children under 18 in the State, with a minimum award of \$175,000 per State. The other part of the grant award will be allotted among the States based on the amount leveraged by the State from private, State, or other non-Federal sources and directed through the State lead agency in the preceding fiscal year for community-based family resource and support services. If the aggregate of these amounts exceeds 30 percent of the appropriation, the amounts for this part of the grant award will be reduced pro rata across the States, which apply for funding under CBFRS.

Funds are used to: (a) develop, operate, expand and enhance Statewide networks of community-based, prevention-focused, family resource and support programs; (b) foster the development of a continuum of preventive services for children and families through State and community-based public and private partnerships; (c) finance the start-up, maintenance, expansion, or redesign of a variety of specific family resource and support program services that have been identified as meeting unmet needs and integrate these within the network of current community-based family resource and support programs; (d) maximize funding for establishing, operating, or expanding a Statewide network of community-based, prevention-focused, and family resource and support programs; and (e) finance public information activities that focus on the healthy and positive development of parents and children and promotion of child abuse and neglect prevention activities.

Funding for the Community-based Family Resource and Support Grants program during the last five years has been as follows:

1999	\$32,835,000
2000	\$32,829,769
2001	\$32,834,000
2002	\$33,412,000
2003	\$33,417,000

Rationale for the Budget Request

The FY 2004 request for the Community-Based Family Resource and Support Grants is \$33,403,000, which is \$14,000 less than the FY 2003 President's Budget. These funds will be used by the States to establish Statewide networks of family support programs that: (1) are based on State and community interagency partnerships, and (2) are implemented through an interdisciplinary, collaborative public-private structure that includes parents as full partners. Lead agencies must seek innovative approaches to blending funds and leveraging additional resources to augment Federal funds. These funds will also support activities and services to help decrease the percentage of children with substantiated reports of maltreatment who have a repeat substantiated report of maltreatment within 6 months from nine percent in 2000 to seven percent in 2004.

The Community-Based Family Resource and Support grantees are in a unique position of leadership as they assume responsibility for providing the network of public-private partnerships and developing the continuum of preventive services for children and families. The safety and welfare of our Nation's children will be best ensured when Federal, State, and community agencies work collaboratively to better target resources and be responsive to the needs of all families. While the need for services to children and families in crisis remains great, it is important that we continue to invest in the kinds of prevention services that are dedicated to supporting families before they go into crisis and risk harming their children.

Resource and Program Data
Community-Based Family Resource and Support Grants

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$31,521,450	\$31,526,450	\$31,526,450
Discretionary	328,306	328,306	328,306
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	1,325,000	1,325,000	1,325,000
Program Support ¹	237,244	237,244	223,244
Total, Resources	\$33,412,000	\$33,417,000	\$33,403,000
<u>Program Data:</u>			
Number of Grants	62	61	61
New Starts:			
#	62	57	57
\$	\$33,012,000	\$31,417,000	\$31,417,000
Continuations:			
#		4	4
\$		\$1,512,756	\$1,512,756
Contracts:			
#	5	5	5
\$	\$400,000	\$487,244	\$473,244
Interagency Agreements:			
#			
\$			

¹Includes funding for information technology support.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN & FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Community-Based Family Resources and Support (CFDA #93.590)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$473,960	\$431,268	\$431,268	\$0
Alaska	237,306	240,793	240,793	0
Arizona	556,642	535,293	535,293	0
Arkansas	194,822	194,265	194,265	0
California	2,551,297	2,667,379	2,667,379	0
Colorado	376,269	296,006	296,006	0
Connecticut	389,987	376,401	376,401	0
Delaware	181,116	181,108	181,108	0
District of Columbia	189,324	190,964	190,964	0
Florida	1,000,012	980,508	980,508	0
Georgia	816,500	846,735	846,735	0
Hawaii	601,599	462,672	462,672	0
Idaho	180,039	177,362	177,362	0
Illinois	886,283	878,801	878,801	0
Indiana	836,257	846,464	846,464	0
Iowa	787,430	446,165	446,165	0
Kansas	746,918	618,215	618,215	0
Kentucky	1,744,416	1,711,257	1,711,257	0
Louisiana	365,576	364,115	364,115	0
Maine	181,095	181,023	181,023	0
Maryland	631,830	504,303	504,303	0
Massachusetts	464,149	490,144	490,144	0
Michigan	885,421	816,732	816,732	0
Minnesota	1,944,929	1,907,167	1,907,167	0
Mississippi	214,776	211,803	211,803	0
Missouri	468,611	454,056	454,056	0
Montana	175,868	179,164	179,164	0
Nebraska	185,231	190,055	190,055	0
Nevada	195,372	197,588	197,588	0
New Hampshire	177,819	178,662	178,662	0
New Jersey	636,183	634,893	634,893	0
New Mexico	260,683	329,912	329,912	0
New York	1,295,765	1,303,700	1,303,700	0
North Carolina	859,495	592,199	592,199	0
North Dakota	179,311	179,636	179,636	0

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2003 Pres. Budget	Difference +/- 2003
Ohio	853,607	1,360,813	1,360,813	0
Oklahoma	1,290,844	1,373,136	1,373,136	0
Oregon	231,656	229,650	229,650	0
Pennsylvania	933,981	941,978	941,978	0
Rhode Island	218,294	217,554	217,554	0
South Carolina	276,784	290,660	290,660	0
South Dakota	177,461	177,025	177,025	0
Tennessee	599,710	567,337	567,337	0
Texas	1,630,764	1,595,750	1,595,750	0
Utah	286,936	285,920	285,920	0
Vermont	253,746	261,923	261,923	0
Virginia	488,969	480,235	480,235	0
Washington	430,913	429,270	429,270	0
West Virginia	246,668	258,838	258,838	0
Wisconsin	416,968	422,773	422,773	0
Wyoming	179,986	183,264	183,264	0
Subtotal	30,389,578	29,872,934	29,872,934	0
Indian Tribes	334,160	334,170	334,030	-140
American Samoa	175,000	175,000	175,000	0
Guam	175,000	175,000	175,000	0
Northern Mariana Islands	175,000	175,000	175,000	0
Puerto Rico	513,262	509,896	510,036	140
Virgin Islands	175,000	175,000	175,000	0
Subtotal	1,547,422	1,544,066	1,544,066	0
Total States/Territories	31,937,000	31,417,000	31,417,000	0
Technical Assistance	400,000	487,244	473,244	-14,000
Other	1,075,000	1,512,756	1,512,756	0
Subtotal Adjustments	1,475,000	2,000,000	1,986,000	-14,000
TOTAL RESOURCES	\$33,412,000	\$33,417,000	\$33,403,000	-\$14,000

CHILD WELFARE SERVICES

Authorizing Legislation -- Section 420, title IV-B of the Social Security Act, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$291,986,000	\$291,986,000	\$291,986,000	\$0

2004 Authorization....Such sums.

Purpose and Method of Operation

The Child Welfare Services program helps State public welfare agencies improve their child welfare services with the goal of keeping families together. State services include: preventive intervention so that, if possible, children will not have to be removed from their homes; services to develop alternative placements like foster care or adoption if children cannot remain at home; and, reunification services so that children can return home, if appropriate, are available to children and their families without regard to income.

Funds are distributed to States in the form of grants. Each State receives a base amount of \$70,000. Additional funds are distributed in proportion to the State's population of children under age 21 multiplied by the complement of the State's average per capita income. The State match requirement is 25 percent.

The 1980 amendments to the Social Security Act link this program (title IV-B) to the title IV-E Foster Care and Adoption Assistance Programs. The 1993 amendments to the Social Security Act created the Family Preservation and Support Services Program (renamed Promoting Safe and Stable Families in 1997) as subpart 2 of the title IV-B Program and joined it to this program (now subpart 1 of Title IV-B) and to the title IV-E programs. The same State agency must administer, or supervise the administration of all the programs. To strengthen the families of at risk children is the broad goal of all the programs. Taken together, these programs provide a continuum of services to help children and their families.

Effective October 1, 1996 protections which States previously had to implement in order to receive the incentive funds under the Child Welfare Services Program, were required to be listed as assurances under the State plan and include: (1) conducting an inventory of all children in foster care for at least six months; (2) establishing an information system for all children in foster care; (3) conducting periodic case reviews of all foster children; and, (4) conducting in-home and permanent placement service programs, including preventive and reunification services.

Since 1983, under Section 428 of the Social Security Act, grants have been awarded directly to eligible Indian tribal organizations. Indian Tribes must meet plan requirements specified in 45 CFR 1357.15.

The Adoption and Safe Families Act's focus on permanency has had a substantial impact on children in the Foster Care Program:

- Between FY 1995 and FY 2001, the number of children adopted per year increased from 26,000 to 50,000.
- In FY 2001, 23 percent of these adoptions occurred within 2 years of the child's most recent removal.
- Over 2/3 (68 percent) of children reunified in FY 2001 were reunified within 1 year of the child's most recent removal.

Funding for the Child Welfare Services program during the last five years has been as follows:

1999	\$291,896,000
2000	\$291,939,480
2001	\$291,986,000
2002	\$291,986,000
2003	\$291,986,000

Rationale for the Budget Request

In order to continue to support children and their families, \$291,986,000 is requested for FY 2004, the same as the FY 2003 President's Budget. The amount requested will support grants to help improve State child welfare services with the goal of keeping families together.

Resource and Program Data
Child Welfare Services

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$291,986,000	\$291,986,000	\$291,986,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$291,986,000	\$291,986,000	\$291,986,000
<u>Program Data:</u>			
Number of Grants	189	194	194
New Starts:			
#	5	5	5
\$	\$50,000	\$50,000	\$50,000
Continuations:			
#	184	189	189
\$	\$291,936,000	\$291,236,000	\$291,936,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Child Welfare Services (CFDA # 93.645)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$5,297,920	\$5,297,920	\$5,297,920	\$0
Alaska	396,099	288,123	288,123	0
Arizona	5,236,735	5,062,086	5,062,086	0
Arkansas	3,313,422	3,313,422	3,313,422	0
California	34,279,968	34,277,539	34,277,539	0
Colorado	3,938,798	3,933,770	3,933,770	0
Connecticut	2,077,666	2,077,666	2,077,666	0
Delaware	777,666	777,666	777,666	0
District of Columbia	367,304	367,304	367,304	0
Florida	14,401,678	14,401,678	14,401,678	0
Georgia	8,891,978	8,891,978	8,891,978	0
Hawaii	1,230,726	1,230,726	1,230,726	0
Idaho	1,777,512	1,775,947	1,775,947	0
Illinois	11,455,352	11,455,352	11,455,352	0
Indiana	6,749,885	6,749,885	6,749,885	0
Iowa	3,243,639	3,243,639	3,243,639	0
Kansas	3,030,218	3,030,218	3,030,218	0
Kentucky	4,684,902	4,684,902	4,684,902	0
Louisiana	5,748,157	5,745,559	5,745,559	0
Maine	1,361,032	1,364,650	1,364,650	0
Maryland	4,566,781	4,566,781	4,566,781	0
Massachusetts	4,591,700	4,593,689	4,593,689	0
Michigan	10,179,221	10,142,283	10,142,283	0
Minnesota	4,631,278	4,614,318	4,614,318	0
Mississippi	3,911,678	3,900,649	3,900,649	0
Missouri	6,024,440	6,024,440	6,024,440	0
Montana	850,564	899,358	899,358	0
Nebraska	1,910,335	1,905,499	1,905,499	0
Nevada	1,845,843	1,845,843	1,845,843	0
New Hampshire	1,168,601	1,168,601	1,168,601	0
New Jersey	5,996,553	5,996,553	5,996,553	0
New Mexico	1,935,253	1,837,471	1,837,471	0
New York	14,940,632	14,940,632	14,940,632	0
North Carolina	8,313,350	8,286,058	8,286,058	0
North Dakota	720,670	700,516	700,516	0

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	11,767,561	11,767,561	11,767,561	0
Oklahoma	2,670,746	2,321,778	2,321,778	0
Oregon	3,452,178	3,468,045	3,468,045	0
Pennsylvania	11,450,186	11,450,186	11,450,186	0
Rhode Island	1,027,670	1,038,434	1,038,434	0
South Carolina	4,744,151	4,744,151	4,744,151	0
South Dakota	771,562	728,612	728,612	0
Tennessee	6,079,722	6,079,722	6,079,722	0
Texas	24,239,729	24,241,805	24,241,805	0
Utah	3,375,986	3,371,294	3,371,294	0
Vermont	707,791	707,791	707,791	0
Virginia	6,582,505	6,582,505	6,582,505	0
Washington	5,562,916	5,554,448	5,554,448	0
West Virginia	2,083,199	2,083,199	2,083,199	0
Wisconsin	5,613,627	5,592,365	5,592,365	0
Wyoming	619,242	619,242	619,242	0
Subtotal	280,596,327	279,743,859	279,743,859	0
Indian Tribes	4,444,335	5,296,803	5,296,803	0
American Samoa	181,628	181,628	181,628	0
Guam	325,814	325,814	325,814	0
Northern Mariana Islands	135,116	135,116	135,116	0
Puerto Rico	6,042,083	6,042,083	6,042,083	0
Virgin Islands	260,697	260,697	260,697	0
Subtotal	11,389,673	12,242,141	12,242,141	0
Total States/Territories	291,986,000	291,986,000	291,986,000	0
TOTAL RESOURCES	\$291,986,000	\$291,986,000	\$291,986,000	\$0

CHILD WELFARE TRAINING

Authorizing Legislation -- Section 426 of title IV-B of the Social Security Act, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$7,487,000	\$7,498,000	\$7,470,000	-\$28,000

2004 Authorization.....Such sums.

Purpose and Method of Operation

The Child Welfare Training program provides discretionary grants to public and private non-profit institutions of higher education to develop and improve education and training programs and resources for child welfare service providers. Applications for funding are selected through a competitive review process. These grants upgrade the skills and qualifications of child welfare workers through their participation, full-time or part-time, in programs focused specifically on child welfare service activities. Child Welfare training grants also provide support to full-time students seeking undergraduate and advanced degrees in social work. Approximately \$1.3 million was awarded to universities to support bachelor of social work students; of those funds, roughly \$1.05 million was spent on actual scholarships.

Funding for the Child Welfare Training program during the last five years has been as follows:

1999	\$7,000,000
2000	\$6,998,885
2001	\$6,998,000
2002	\$7,487,000
2003	\$7,498,000

Rationale for the Budget Request

In order to continue to support training for child welfare professionals and students and support the need for trained personnel in child welfare, \$7,470,000 is requested for FY 2004, which is \$28,000 less than the FY 2003 President's Budget. The amount requested will support grants to expand training resources and opportunities in the field of child welfare.

Resource and Program Data
Child Welfare Training

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	\$7,246,247	\$6,951,351	\$7,001,351
Program Support ¹	240,753	546,649	468,649
Total, Resources	\$7,487,000	\$7,498,000	\$7,470,000
<u>Program Data:</u>			
Number of Grants	40	36	36
New Starts:			
#		36	
\$		\$6,250,000	
Continuations:			
#	40		36
\$	\$6,802,337		\$6,250,000
Contracts:			
#	5	6	5
\$	\$684,663	\$1,248,000	\$1,220,000
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support, and grant/paneling review. FY 2004 includes a reduction in information technology support.

ADOPTION OPPORTUNITIES

Authorizing Legislation -- Legislation to reauthorize section 205 of the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978 is pending Congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$27,335,000	\$27,405,000	\$27,343,000	-\$62,000

2004 Authorization....Such sums (as requested in the pending FY 2002 straight-line reauthorization).

Purpose and Method of Operation

The Adoption Opportunities program funds grants and contracts to public and private organizations to facilitate the elimination of barriers to adoption and to provide permanent, loving home environments for children who would benefit from adoption, particularly children with special needs.

There are approximately 134,000 children in the public foster care system that cannot return safely to their own homes and parents. About 64,000 of these children are legally free and immediately available for adoption. Such children are typically school-aged, in sibling groups, have experienced neglect or abuse, or have a physical, mental, or emotional disability.

Major activities are: (1) the development and implementation of a national adoption and foster care data gathering and analysis system; (2) the development and implementation of a national adoption information exchange system; (3) the development and implementation of an adoption training and technical assistance program; (4) increasing the placements in adoptive families of minority children who are in foster care and have the goal of adoption with a special emphasis on recruitment of minority families; (5) increasing post-legal adoption services for families who have adopted children with special needs; (6) studying the nature, scope, and effects of placement of children in kinship care arrangements, pre-adoptive, or adoptive homes; and (7) studying the efficacy of States contracting with public or private non-profit agencies (including community-based and other organizations). In these areas, demonstration grants are awarded through a competitive process to public and private non-profit agencies including State and local governments, universities and voluntary agencies. These demonstration grants test new models of service delivery to address and eliminate barriers to adoption and help find permanent families for children who would benefit by adoption, particularly children with special needs.

The Adoption Opportunities program is a component of the Department of Health and Human Services' efforts to increase the number of children who are adopted or permanently placed from the child welfare system each year. The percentage of children who exited the foster care system through adoption within two years of placement increased from 19 percent in FY 1999 to

23 percent in FY 2001. In addition, the percentage of children who exited the foster care system through reunification within one year of placement increased from 65 percent in FY 1999 to 68 percent in FY 2001.

Funding for the Adoption Opportunities program during the last five years has been as follows:

1999	\$24,916,828
2000	\$27,414,000
2001	\$27,379,000
2002	\$27,335,000
2003	\$27,405,000

Rationale for the Budget Request

In order to provide loving parents and safe and stable homes for the maximum number of children available for adoption, \$27,343,000 is requested for FY 2004, which is \$62,000 less than the FY 2003 President's Budget. The amount requested will support grants to facilitate the adoption process and technical assistance to enable States to increase the number of children adopted, especially children with special needs.

Resource and Program Data
Adoption Opportunities

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development	\$22,223,053	\$20,721,444	\$20,780,639
Training/Technical Assistance	4,583,044	5,283,756	5,175,016
Program Support ¹	528,902	1,399,800	1,387,345
Total, Resources	\$27,334,999	\$27,405,000	\$27,343,000
<u>Program Data:</u>			
Number of Grants	80	105	105
New Starts:			
#	14	26	
\$	\$5,493,588	\$10,000,000	
Continuations:			
#	66	79	105
\$	\$18,438,039	\$12,801,444	\$23,193,895
Contracts:			
#	8	6	9
\$	\$3,049,951	\$4,603,556	\$4,149,105
Interagency Agreements:			
#	3		
\$	\$335,912		

¹ Includes funding for information technology support, increased grant/paneling reviews, and printing cost. FY 2004 includes a reduction in information technology support.

ABANDONED INFANTS ASSISTANCE PROGRAM

Authorizing Legislation – Legislation to reauthorize section 104(a)(1) of the Abandoned Infants Assistance Act of 1988 is pending Congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$12,194,000	\$12,205,000	\$12,086,000	-\$119,000

2004 Authorization....Such sums (as requested in the pending FY 2002 straight-line reauthorization).

Purpose and Method of Operation

Consistent with the strategic goal of improving healthy development, safety and well-being of children and youth and with the strategic objective of providing children with permanency and stability in their living situations, the Abandoned Infants Assistance program provides grants to public and private community and faith-based entities for development, implementation and operation of projects to demonstrate how to: (1) prevent abandonment of infants and young children exposed to HIV/AIDS and drugs, including the provision of services to family members for any condition that increases the probability of abandonment of an infant or young child; (2) identify and address the needs of abandoned infants, especially those born with AIDS and those exposed to drugs; (3) assist these children to reside with their natural families, if possible, or in foster care; (4) recruit, train and retain foster parents; (5) carry out residential care programs for abandoned children and children with AIDS; (6) establish programs of respite care for families and foster families; (7) recruit and train health and social services personnel to work with families, foster families and residential care staff; and (8) prevent the abandonment of infants and young children by providing needed resources through model programs.

This program also funds technical assistance, including training, with respect to the planning, development and operation of the projects. Several of the AIA projects have been instrumental in reducing the length of time infants board in hospitals. The New Start Project, Newark, New Jersey, served nearly 2,000 children and families over a three-year period and reduced the length of hospitalization after medical discharge by 77 percent, from an average of 45 days to ten days. The project at the Yale Child Study Center, New Haven, Connecticut, achieved a significant reduction in the number of days that cocaine exposed infants spent in the hospital during the neonatal period (5 days vs. 9 days). Furthermore, the children exposed to cocaine spent no longer time in the hospital than a non-cocaine comparison group.

Funding for the Abandoned Infants Assistance program during the last five years has been as follows:

1999	\$12,241,000
2000	\$12,205,055
2001	\$12,182,000
2002	\$12,193,983
2003.....	\$12,205,000

Rationale for the Budget Request

The FY 2004 request for Abandoned Infants of \$12,086,000, which is \$119,000 less than the FY 2003 President's Budget, will support service demonstration grants to prevent the abandonment of infants and young children with AIDS and drug-exposed infants and young children and to reunify and strengthen families impacted by substance abuse by providing supportive services to family caregivers and to children and adolescents in a recreational or camp setting. With the increase of AIDS among women, and the continued high incidence of alcohol and drug use among pregnant women, the program is needed for services to maintain and enhance family stability and to find both temporary and permanent loving homes for abandoned infants.

Resource and Program Data
Abandoned Infants

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development	\$10,874,149	\$10,868,123	\$10,618,601
Training/Technical Assistance	931,887	975,000	975,000
Program Support ¹	387,947	361,877	492,399
Total, Resources	\$12,193,983	\$12,205,000	\$12,086,000
<u>Program Data:</u>			
Number of Grants	36	37	35
New Starts:			
#	1		19
\$	\$700,000		\$6,400,000
Continuations:			
#	35	37	16
\$	\$10,891,685	\$11,568,123	\$4,918,601
Contracts:			
#	5	3	3
\$	\$602,298	\$636,877	\$767,399
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support and increased grant/paneling reviews. FY 2004 includes a reduction in information technology support.

ADOPTION INCENTIVES

Authorizing Legislation – Legislation to reauthorize section 473A of the Social Security Act will be proposed.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$43,000,000	\$43,000,000	\$43,000,000	\$0

2004 Authorization....\$43,000,000 (as requested in pending proposed reauthorization legislation).

Purpose and Method of Operation

The Adoption Incentive Program was created as part of the Adoption and Safe Families Act of 1997. The program authorizes the payment of adoption incentive funds to States that are successful in increasing the number of children who are adopted from the public foster care system. The amount of the payments to States is based on increases in the number of children adopted from the foster care system in a year, relative to a baseline number. For each child adopted over the baseline number, a State is eligible to receive \$4,000. For each adopted child with special needs, the State is eligible to receive an additional \$2,000, contingent on funding. In cases where the number of adoptions exceeds the funds appropriated by Congress to pay for the incentive awards, the law specifies that there is to be a pro-rated adjustment in the awards to States.

The Adoption Incentive Program has been successful in contributing to the substantial increase in adoptions in recent years. However, while the overall number of children being adopted has grown dramatically, some groups of children needing a permanent home remain less likely to be adopted. For instance, analysis of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) shows that once a child waiting for adoption reaches 8 or 9 years old, the probability that the child will continue to wait in foster care exceeds the probability that the child will be adopted. Furthermore, based on more recent analysis of AFCARS data, older children constitute an increasing proportion of the pool of children waiting for adoptive families.

The legislative authority for the Adoption Incentive Program expires at the end of FY 2003. Legislation to reauthorize and amend the program to target incentives specifically to older children is proposed. Under the proposal, ACF will award incentives using two independent baselines: one for the total number of children adopted from the public foster care system; and the other for children age nine and older adopted from the public foster care system. Awarding the incentive funds in this way maintains the incentive for achieving increased adoptions for older children for all States, regardless of how high their baseline for the total number of adoptions is for any fiscal year. Once the State has reached the baseline for the total number of

adoptions for the year, it will receive a \$4,000 bonus for each child who is adopted from the public child welfare system. Additionally, once the State has reached the baseline for the number of adoptions for children age 9 and older for that year, the State will receive a \$6,000 bonus for each child who is adopted from the public child welfare system.

Funding for the Adoption Incentives program since its inception in FY 1999 as follows:

1999	\$19,994,999
2000	\$41,784,342
2001	\$42,994,000
2002	\$43,000,000
2003	\$43,000,000

Rationale for the Budget Request

The FY 2004 request is \$43,000,000, the same as the FY 2003 President's Budget. This amount will allow ACF to fully pay any incentives due to States under the current system and begin awards under the proposed system without any back payments due to States. Just as the original Adoption Incentive Program focused greater attention on the need to increase adoptions overall and helped mobilize States to action on behalf of waiting children, this new proposal will focus State attention on meeting the needs of children and youth who traditionally have been less likely to be considered as candidates for adoption.

The original Adoption Incentives program set a goal for doubling the number of adoptions by FY 2002. We propose to set a new goal in alignment with the reauthorization request which would increase the total number of adoptions with public child welfare involvement to 300,000 adoptions between FY 2004 and FY 2008. Between FY 1998 and FY 2002, we currently project that a total of 238,000 children will have been adopted. With the new requirements implemented under the Adoption and Safe Families Act, we believe the new goal of 300,000 adoptions over 5 years is a substantial but achievable goal for States as they strive to find safe, permanent homes for children in the public child welfare system.

Resource and Program Data
Adoption Incentives

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$39,965,658	\$43,000,000	\$43,000,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$39,965,658	\$43,000,000	\$43,000,000
<u>Program Data:</u>			
Number of Grants		N/A	N/A
New Starts:			
#	24	N/A	N/A
\$	\$17,502,000	N/A	N/A
Continuations:			
#	36	1	
\$	\$22,463,258	\$76,000 ¹	
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

¹ This amount awarded to New Mexico from remaining FY 2002 funds to correct a mis-calculation of the FY 2002 award.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Adoption Incentives (CFDA #93.603)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget¹	FY 2004 Estimate¹	Difference +/- 2003
Alabama	\$315,762	n/a	n/a	
Alaska	658,172	n/a	n/a	
Arizona	846,276	n/a	n/a	
Arkansas	315,224	n/a	n/a	
California	12,791,424	n/a	n/a	
Colorado	0	n/a	n/a	
Connecticut	259,524	n/a	n/a	
Delaware	339,083	n/a	n/a	
District of Columbia	233,842	n/a	n/a	
Florida	250,062	n/a	n/a	
Georgia	0	n/a	n/a	
Hawaii	0	n/a	n/a	
Idaho	34,000	n/a	n/a	
Illinois	0	n/a	n/a	
Indiana	1,066,480	n/a	n/a	
Iowa	18,924	n/a	n/a	
Kansas	0	n/a	n/a	
Kentucky	914,948	n/a	n/a	
Louisiana	447,408	n/a	n/a	
Maine	786,681	n/a	n/a	
Maryland	1,510,000	n/a	n/a	
Massachusetts	0	n/a	n/a	
Michigan	2,277,618	n/a	n/a	
Minnesota	310,888	n/a	n/a	
Mississippi	220,325	n/a	n/a	
Missouri	1,388,181	n/a	n/a	
Montana	362,367	n/a	n/a	
Nebraska	321,316	n/a	n/a	
Nevada	152,122	n/a	n/a	
New Hampshire	108,135	n/a	n/a	
New Jersey	1,512,582	n/a	n/a	
New Mexico	516,625	n/a	n/a	
New York	0	n/a	n/a	
North Carolina	1,300,321	n/a	n/a	
North Dakota	0	n/a	n/a	

¹ For both FY 2003 and FY 2004, it is unknown which States will qualify for awards and how much those awards will be.

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	2,274,516	n/a	n/a	
Oklahoma	381,175	n/a	n/a	
Oregon	1,709,383	n/a	n/a	
Pennsylvania	670,436	n/a	n/a	
Rhode Island	0	n/a	n/a	
South Carolina	0	n/a	n/a	
South Dakota	45,517	n/a	n/a	
Tennessee	919,542	n/a	n/a	
Texas	1,408,570	n/a	n/a	
Utah	0	n/a	n/a	
Vermont	0	n/a	n/a	
Virginia	922,000	n/a	n/a	
Washington	1,536,038	n/a	n/a	
West Virginia	311,609	n/a	n/a	
Wisconsin	379,824	n/a	n/a	
Wyoming	6,758	n/a	n/a	
Subtotal²	39,823,658			
Puerto Rico	218,000	n/a	n/a	
Subtotal	218,000			
Total States/Territories	40,041,658	43,000,000	43,000,000	
TOTAL RESOURCES	\$40,041,658	\$43,000,000	\$43,000,000	

² Funds awarded to New Mexico in FY 2003 from remaining FY 2002 funds to correct a mis-calculation of the FY 2002 award are included in the FY 2002 Actual column.

CHILDREN'S HEALTH ACT – INFANT ADOPTION AWARENESS (PART A)

Authorizing Legislation –Section 330F of title III of the Public Health Service Act

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$9,906,000	\$9,906,000	\$9,906,000	\$0

2004 Authorization....Such sums.

Purpose and Method of Operation

The Infant Adoption Awareness program, created in the Children's Health Act of 2000, awards grants to support adoption organizations in the training of designated staff in eligible public and private, non-profit health centers that provide health services to pregnant women to inform them about adoption and make referrals on request to adoption agencies on an equal basis with all other courses of action. The program also supports development of best practice guidelines on adoption counseling to be used by the grantees and an evaluation of the extent to which the training is effective. All four grantees in the Infant Adoption Awareness Training Program have begun training. The four grantees represent efforts on the state, regional, and national level.

Funding for the Infant Adoption Awareness program has been as follows:

2001.....	\$9,900,000
2002.....	\$9,906,000
2003.....	\$9,906,000

Rationale for the Budget Request

The FY 2004 request is \$9,906,000, the same as the FY 2003 President's Budget. Continued funding will ensure that staff is sufficiently trained to inform pregnant women about all of their options, including adoption, as well as refer women on request to adoption agencies.

Resource and Program Data
Children's Health Act – Infant Adoption Awareness

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	\$9,906,000	\$9,906,000	\$9,896,000
Program Support ¹			10,000
Total, Resources	\$9,906,000	\$9,906,000	\$9,906,000
<u>Program Data:</u>			
Number of Grants	4	4	4
New Starts:			
#			4
\$			\$9,335,280
Continuations:			
#	4	4	
\$	\$9,906,000	\$9,345,280	
Contracts:			
#		1	2
\$		\$560,720	\$570,720
Interagency Agreements:			
#			
\$			

¹ Includes funding for grant/paneling review.

CHILDREN'S HEALTH ACT – SPECIAL NEEDS ADOPTION AWARENESS (PART B)

Authorizing Legislation -- Section 330G of title III of the Public Health Service Act

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$3,000,000	\$3,000,000	\$3,000,000	\$0

2004 Authorization....Such sums

Purpose and Method of Operation

The Special Needs Adoption Awareness program created by the Children's Health Act of 2000 provides for grants to be made to non-profit, private entities for the planning, development and carrying out of a national campaign informing the public about the adoption of children with special needs. This campaign can include public service announcements on television, radio or billboards, as well as other means determined to be effective in reaching people likely to adopt children with special needs.

Funds from the Special Needs Adoption Awareness program fund the Children's Bureau's AdoptUSKids initiative. AdoptUSKids is designed to find and support adoptive families for waiting children by providing new and enhanced recruitment tools, training and technical assistance to States and tribes through a five-year cooperative agreement with the Adoption Exchange Association. The project "The Collaboration to AdoptUSKids" will:

- Maintain and enhance the AdoptUSKids.org web site (the first federal adoption photolisting web site)
- Provide training and technical assistance on the recruitment of adoptive and foster homes to States and tribes throughout the country;
- Develop and implement a national adoption recruitment campaign;
- Create a support network of adoptee, adoptive family and sibling groups;
- Conduct research to identify the barriers to the adoption process and components to favorable long-term outcomes for families adopting children with special needs; and
- Enhance collaboration between agencies and individuals working to find families for children.

The project will bring together the expertise of several organizations. In addition to the Adoption Exchange Association, the Child Welfare League of America, the University of Texas

at Austin, the Northwest Adoption Exchange, the Adoption Exchange and Holt International Children's Services will all play important roles.

Funding for the Special Needs Adoption Awareness program has been as follows:

2002.....	\$3,000,000
2003.....	\$3,000,000

Rationale for Budget Request

The FY 2004 request is \$3,000,000, the same as the FY 2003 appropriation level. It is critically important to publicize the need for adoption of children with special needs so that permanent, loving home environments can be found for these vulnerable children and to support families who are willing to provide homes for children with special needs.

Resource and Program Data
Children's Health Act - Special Needs Adoption Awareness (Part B)

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	\$2,839,000	\$2,839,000	\$2,839,000
Program Support ¹	161,000	161,000	161,000
Total, Resources	\$3,000,000	\$3,000,000	\$3,000,000
<u>Program Data:</u>			
Number of Grants	1	1	1
New Starts:			
#	1		
\$	\$2,839,000		
Continuations:			
#		1	1
\$		\$2,839,000	\$2,839,000
Contracts:			
#			
\$			
Interagency Agreements:			
#	1	1	1
\$	\$161,000	\$161,000	\$161,000

¹ Includes funding for an evaluation set-aside for all programs funded under the Public Health Services Act.

DEVELOPMENTAL DISABILITIES (STATE COUNCILS)

Authorizing Legislation -- Section 129 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$69,800,000	\$69,800,000	\$69,800,000	\$0

2004 Authorization....Such sums.

Purpose and Method of Operation

The State Councils on Developmental Disabilities Program assists each State in promoting the development of a comprehensive, statewide, consumer and family-centered system that provides a coordinated array of culturally-competent services, and other assistance for individuals with developmental disabilities. The goals of a Council are to: (a) enhance the ability of persons with developmental disabilities to live, work, and engage in leisure activities in their communities; (b) support State and other programs that develop, coordinate and/or stimulate permanent improvement in service systems; and (c) give priority to people whose needs are not otherwise met under other health, education and human services programs.

In order to qualify for funds, States must submit a plan and establish a State Council on Developmental Disabilities to advocate for services and activities for all people with developmental disabilities. There are 55 councils. Up to forty percent of the council's membership includes representatives of major State agencies, non-governmental agencies and other concerned groups. Not less than sixty percent of the membership must include persons with developmental disabilities, their parents or guardians. Councils engage in a range of activities including, but not limited to, program and policy analysis, demonstration of new approaches, training, outreach, community support, interagency collaboration and coordination, public education, and prevention in the following areas of emphasis as required in the law: (1) quality assurance, (2) education and early intervention, (3) child care, (4) health, (5) employment (6) housing, (7) transportation, (8) recreation, and (9) other services available or offered to individuals in a community, including formal and informal community supports, that affect their quality of life.

Funding for Developmental Disabilities Councils is allotted among the States on the basis of population, and the extent of need for services for persons with developmental disabilities, weighted by the relative per capita income for each State. The grants are made to designated State agencies or councils to support the councils in implementing the approved state plan. The aggregate Federal share of projects under such grants may not exceed seventy-five percent except in the case of projects in poverty areas, where the Federal share may not exceed ninety percent. In the case of projects conducted by council members or staff to implement State plan

priority activities the Federal share may be up to one hundred percent of the aggregate necessary cost of such activities.

Funding for the Developmental Disabilities State Council Grant program during the last five years has been as follows:

1999.....	\$64,803,000
2000.....	\$65,750,000
2001.....	\$67,800,000
2002.....	\$69,800,000
2003.....	\$69,800,000

Rationale for the Budget Request

The FY 2004 request for the Developmental Disabilities State Council program is \$69,800,000, the same level as the FY 2003 President's Budget. This level of funding will continue to support advocacy, systems change and capacity building activities that improve State services and supports for people with developmental disabilities and their families.

Resource and Program Data
State Councils on Developmental Disabilities

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$69,800,000	\$69,800,000	\$69,800,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$69,800,000	\$69,800,000	\$69,800,000
<u>Program Data:</u>			
Number of Grants	55	55	55
New Starts:			
#			
\$			
Continuations:			
#	55	55	55
\$	\$69,800,000	\$69,800,000	\$69,800,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Developmental Disabilities Councils (CFDA # 93.630)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$1,283,663	\$1,285,711	\$1,285,711	\$0
Alaska	446,374	446,374	446,374	0
Arizona	1,056,129	1,121,495	1,121,495	0
Arkansas	762,418	789,163	789,163	0
California	6,543,380	6,385,753	6,385,753	0
Colorado	733,877	754,297	754,297	0
Connecticut	639,635	637,453	637,453	0
Delaware	446,374	446,374	446,374	0
District of Columbia	446,374	446,374	446,374	0
Florida	3,311,207	3,438,186	3,438,186	0
Georgia	1,807,722	1,847,000	1,847,000	0
Hawaii	446,374	446,374	446,374	0
Idaho	446,374	446,374	446,374	0
Illinois	2,624,831	2,615,776	2,615,776	0
Indiana	1,488,546	1,483,364	1,483,364	0
Iowa	743,276	741,508	741,508	0
Kansas	614,589	608,716	608,716	0
Kentucky	1,187,596	1,181,052	1,181,052	0
Louisiana	1,315,691	1,331,411	1,331,411	0
Maine	446,374	446,374	446,374	0
Maryland	1,008,160	1,005,718	1,005,718	0
Massachusetts	1,298,126	1,282,287	1,282,287	0
Michigan	2,469,330	2,427,059	2,427,059	0
Minnesota	1,025,295	1,020,449	1,020,449	0
Mississippi	914,238	925,309	925,309	0
Missouri	1,353,961	1,357,149	1,357,149	0
Montana	446,374	446,374	446,374	0
Nebraska	446,374	446,374	446,374	0
Nevada	446,374	446,374	446,374	0
New Hampshire	446,374	446,374	446,374	0
New Jersey	1,553,320	1,555,524	1,555,524	0
New Mexico	490,241	505,480	505,480	0
New York	3,964,223	4,026,994	4,026,994	0
North Carolina	1,910,719	1,949,039	1,949,039	0
North Dakota	446,374	446,374	446,374	0

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	2,846,721	2,808,310	2,808,310	0
Oklahoma	897,250	896,268	896,268	0
Oregon	729,341	741,028	741,028	0
Pennsylvania	2,979,345	2,979,037	2,979,037	0
Rhode Island	446,374	446,374	446,374	0
South Carolina	1,097,001	1,109,913	1,109,913	0
South Dakota	446,374	446,374	446,374	0
Tennessee	1,461,395	1,485,376	1,485,376	0
Texas	4,384,764	4,418,646	4,418,646	0
Utah	545,015	560,646	560,646	0
Vermont	446,374	446,374	446,374	0
Virginia	1,501,929	1,493,292	1,493,292	0
Washington	1,149,422	1,141,734	1,141,734	0
West Virginia	674,547	662,448	662,448	0
Wisconsin	1,293,164	1,283,244	1,283,244	0
Wyoming	446,374	446,374	446,374	0
Subtotal	66,355,677	66,551,445	66,551,445	0
American Samoa	234,348	234,348	234,348	0
Guam	234,348	234,348	234,348	0
Northern Mariana Islands	234,348	234,348	234,348	0
Puerto Rico	2,506,931	2,311,163	2,311,163	0
Virgin Islands	234,348	234,348	234,348	0
Subtotal	3,444,323	3,248,555	3,248,555	0
Total States/Territories	69,800,000	69,800,000	69,800,000	0
TOTAL RESOURCES	\$69,800,000	\$69,800,000	\$69,800,000	\$0

DEVELOPMENTAL DISABILITIES (PROTECTION AND ADVOCACY)

Authorizing Legislation - Section 145 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$35,000,000	\$35,000,000	\$35,000,000	\$0

2004 Authorization....Such sums.

Purpose and Method of Operation

The Developmental Disabilities Protection and Advocacy program provides grants to establish and maintain a protection and advocacy system in each State to protect the legal and human rights of all persons with developmental disabilities. There are 57 state protection and advocacy systems. Protection and Advocacy funding is allotted among the States based on a formula that takes into account the population, the extent of need for services for persons with developmental disabilities, and the financial need of each State. The protection and advocacy system must have the authority under this program to pursue legal, administrative, and other appropriate remedies or approaches, including the authority to investigate incidents of abuse and neglect and to access client records. The protection and advocacy system must be independent of any agency that provides such services.

Funding for the Protection and Advocacy program during the last five years has been as follows:

1999.....	\$26,718,000
2000.....	\$28,110,000
2001.....	\$33,000,000
2002.....	\$35,000,000
2003.....	\$35,000,000

Rationale for the Budget Request

The FY 2004 request for the Protection and Advocacy Program is \$35,000,000, the same level as the FY 2003 President's Budget. This level of funding will continue to provide advocacy services to individuals with developmental disabilities, provide for the pursuit of class-action advocacy as required, and the provision of information and referral services.

Resource and Program Data
Developmental Disabilities Protection and Advocacy

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$34,300,000	\$34,300,000	\$34,300,000
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	664,991	664,991	664,991
Program Support ¹	35,009	35,009	35,009
Total, Resources	\$35,000,000	\$35,000,000	\$35,000,000
<u>Program Data:</u>			
Number of Grants	57	57	57
New Starts:			
#			
\$			
Continuations:			
#	57	57	57
\$	\$34,300,000	\$34,300,000	\$34,300,000
Contracts:			
#	1	1	1
\$	\$664,991	\$664,991	\$664,991
Interagency Agreements:			
#	1	1	1
\$	\$35,009	\$35,009	\$35,009

¹ Includes funding for contract fees.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Developmental Disabilities Protection and Advocacy (CFDA #93.630)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$577,381	\$578,462	\$578,462	\$0
Alaska	333,400	333,400	333,400	0
Arizona	481,860	510,837	510,837	0
Arkansas	342,954	355,110	355,110	0
California	2,944,722	2,874,486	2,874,486	0
Colorado	365,076	374,374	374,374	0
Connecticut	346,433	345,433	345,433	0
Delaware	333,400	333,400	333,400	0
District of Columbia	333,400	333,400	333,400	0
Florida	1,489,867	1,547,567	1,547,567	0
Georgia	813,299	831,243	831,243	0
Hawaii	333,400	333,400	333,400	0
Idaho	333,400	333,400	333,400	0
Illinois	1,180,647	1,176,955	1,176,955	0
Indiana	669,613	667,478	667,478	0
Iowa	340,450	340,000	340,000	0
Kansas	333,400	333,400	333,400	0
Kentucky	534,120	531,337	531,337	0
Louisiana	591,736	598,988	598,988	0
Maine	333,400	333,400	333,400	0
Maryland	453,580	452,605	452,605	0
Massachusetts	583,738	576,790	576,790	0
Michigan	1,110,559	1,091,837	1,091,837	0
Minnesota	461,218	459,176	459,176	0
Mississippi	411,202	416,307	416,307	0
Missouri	609,069	610,676	610,676	0
Montana	333,400	333,400	333,400	0
Nebraska	333,400	333,400	333,400	0
Nevada	333,400	333,400	333,400	0
New Hampshire	333,400	333,400	333,400	0
New Jersey	698,666	699,877	699,877	0
New Mexico	333,400	333,400	333,400	0
New York	1,782,631	1,811,462	1,811,462	0
North Carolina	859,512	877,066	877,066	0
North Dakota	333,400	333,400	333,400	0

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	1,280,363	1,263,454	1,263,454	0
Oklahoma	403,708	403,390	403,390	0
Oregon	349,503	352,753	352,753	0
Pennsylvania	1,339,885	1,340,145	1,340,145	0
Rhode Island	333,400	333,400	333,400	0
South Carolina	493,458	499,417	499,417	0
South Dakota	333,400	333,400	333,400	0
Tennessee	657,310	668,314	668,314	0
Texas	1,973,255	1,989,098	1,989,098	0
Utah	333,400	333,400	333,400	0
Vermont	333,400	333,400	333,400	0
Virginia	675,665	671,977	671,977	0
Washington	517,232	513,912	513,912	0
West Virginia	358,713	358,836	358,836	0
Wisconsin	581,669	577,382	577,382	0
Wyoming	333,400	333,400	333,400	0
Subtotal	32,280,294	32,367,944	32,367,944	0
Indian Tribes	178,367	178,367	178,367	0
American Samoa	178,367	178,367	178,367	0
Guam	178,367	178,367	178,367	0
Northern Mariana Islands	178,367	178,367	178,367	0
Puerto Rico	1,127,871	1,040,221	1,040,221	0
Virgin Islands	178,367	178,367	178,367	0
Subtotal	2,019,706	1,932,056	1,932,056	0
Total States/Territories	34,300,000	34,300,000	34,300,000	0
Technical Assistance	700,000	700,000	700,000	0
Subtotal Adjustments	700,000	700,000	700,000	0
TOTAL RESOURCES	\$35,000,000	\$35,000,000	\$35,000,000	\$0

DEVELOPMENTAL DISABILITIES (PROJECTS OF NATIONAL SIGNIFICANCE)

Authorizing Legislation -- Section 163 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$11,684,000	\$11,734,000	\$11,642,000	-\$92,000

2004 Authorization....Such sums.

Purpose and Method of Operation

Projects of National Significance is a discretionary program for grants, contracts, or cooperative agreements to public or private nonprofit entities that create opportunities for individuals with developmental disabilities to contribute to, and participate in, all facets of community life. These projects also support the development of national and State policies, including Federal interagency initiatives.

The projects focus on the most pressing issues affecting people with developmental disabilities and their families. They allow for local implementation of practical solutions and provide results and information for possible national replication. The Projects of National Significance budget supports technical assistance, research regarding emerging disability issues, and conferences and special meetings. It provides the Administration on Developmental Disabilities with the funds to expand or otherwise improve the opportunities for individuals with developmental disabilities to achieve full independence, productivity and inclusion in American society. Recently, grants were awarded in such areas as child care, education/early intervention, employment, health, housing, quality assurance and recreation. These projects enhance the lives of individuals with developmental disabilities through the promotion of activities and models designed to enhance their ability to live, work and play in their communities.

Funding for the Projects of National Significance program during the last five years has been as follows:

1999.....	\$10,186,041
2000.....	\$10,244,519
2001.....	\$10,915,000
2002.....	\$11,684,000
2003.....	\$11,734,000

Rationale for the Budget Request

The FY 2004 budget request for the Projects of National Significance Program (PNS) is \$11,642,000, which is \$92,000 less than the FY 2003 President's Budget. The level of funding will continue to provide grants on family support activities; data collection and analysis; technical assistance to State Councils and University Centers; and other projects to improve opportunities for individuals with developmental disabilities (e.g., through the President's New Freedom Initiative and TANF).

Resource and Program Data
Developmental Disabilities Projects of National Significance

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$9,595,497	\$9,600,000	\$9,600,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	1,377,896	1,321,007	1,321,007
Program Support ¹	681,831	812,993	720,993
Total, Resources	\$11,655,224	\$11,734,000	\$11,642,000
Program Data:			
Number of Grants	89	77	77
New Starts:			
#	55	52	52
\$	\$5,458,762	\$6,829,618	\$6,829,618
Continuations:			
#	34	24	24
\$	\$4,136,735	\$2,770,382	\$2,770,382
Contracts:			
#	7	7	7
\$	\$1,377,896	\$1,321,007	\$1,321,007
Interagency Agreements:			
#	6	6	6
\$	\$566,745	\$697,964	\$605,964

¹ Includes funding for information technology support, contract fees, associated overhead costs, printing costs, an interagency agreement and support for Departmental evaluation activities.

DEVELOPMENTAL DISABILITIES CENTERS FOR EXCELLENCE
(FORMERLY KNOWN AS UNIVERSITY AFFILIATED PROGRAMS)

Authorizing Legislation -- Section 156 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
\$24,000,000	\$24,000,000	\$24,000,000	\$0

2004 Authorization....Such sums.

Purpose and Method of Operation

Centers for Excellence in Developmental Disabilities (CEDDs) are interdisciplinary education, research and public service units of a university system or are public or not-for-profit entities associated with universities. Grants to establish these CEDDs were initially made on a competitive basis and the national network now consists of 61 CEDDs. Awards are made for 5 years. These CEDDs provide for interdisciplinary training, community services, research, and technical assistance and information/dissemination activities. CEDDs support activities that address the individual needs of persons with developmental disabilities from birth through old age and address a variety of service issues from prevention to early intervention to supported employment. CEDDs must provide community services on behalf of persons with developmental disabilities through a variety of mechanisms including clinical services programs, community-based services programs, technical assistance to community services personnel and State agencies, and dissemination of information.

Grant funds are distributed in accordance with the Act in the following order of funding priorities: (1) continuation of existing CEDDs in an amount up to \$500,000 (The level of funding under the FY 2004 budget for each CEDD would be \$382,888); (2) grants for National training initiatives on critical and emerging needs for individuals with developmental disabilities and their families; and (3) grants to additional CEDDs or additional grants to CEDDs, for states or populations that are unserved or under served by CEDDs due to such factors as population, a high concentration of rural or urban areas; or a high concentration of unserved or under served populations.

Funding for the CEDDs program during the last five years has been as follows:

1999.....	\$17,461,000
2000.....	\$18,171,000
2001.....	\$21,800,000
2002.....	\$24,000,000
2003.....	\$24,000,000

Rationale for the Budget Request

The FY 2004 request for the CEDDs program is \$24,000,000, the same as the FY 2003 President's Budget. In FY 2004 funds will continue to provide operational and administrative support to establish a national network of CEDDs and build upon current activities.

Resource and Program Data
 Developmental Disabilities Centers for Excellence
 (formerly known as University Affiliated Programs)

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$23,356,168	\$23,356,168	\$23,356,168
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	343,783	343,832	343,832
Program Support ¹	300,000	300,000	300,000
Total, Resources	\$23,999,951	\$24,000,000	\$24,000,000
Program Data:			
Number of Grants	61	61	61
New Starts:			
#	42	17	2
\$	\$16,081,296	\$6,509,096	\$765,776
Continuations:			
#	19	44	59
\$	\$7,274,872	\$16,847,072	\$22,590,392
Contracts:			
#	1	1	1
\$	\$343,783	\$343,832	\$343,832
Interagency Agreements:			
#	1	1	1
\$	\$300,000	\$300,000	\$300,000

¹ This includes funding for grant/panel review costs

NATIVE AMERICAN PROGRAMS

Authorizing Legislation -- Legislation to reauthorize sections 816 of the Native American Programs Act of 1974, as amended is pending Congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$45,912,000	\$45,196,000	\$45,119,000	-\$77,000

2004 Authorization....Such sums (as included in the FY 2003 proposed straight-line reauthorization of the program pending Congressional action).

Purpose and Method of Operation

The Native American Programs Act is the only Federal program serving all Native Americans regardless of where they live or their tribal or group affiliation. The Native American Programs Act promotes self-sufficiency of American Indians, Alaska Natives, Native Hawaiians, and Native American Pacific Islanders by encouraging local strategies in economic and social development. The Administration for Native Americans (ANA) defines self-sufficiency as the level of development at which a Native American community can control and internally generate resources to provide for the needs of its members and meet its own short and long range social and economic goals. Social and economic underdevelopment is the paramount obstacle to the self-sufficiency of Native American communities and families.

Native American programs include financial assistance for social and economic development and governance, training and technical assistance, and research, demonstration and evaluation projects. Assistance is provided through direct grants, contracts and interagency agreements. Native American programs and their policies foster a balanced developmental approach at the community level through three major goals: (1) Governance: To strengthen Tribal governments, Native American institutions and local leadership to assure local control over all resources; (2) Economic Development: To foster the development of stable, diversified local economies to provide jobs and reduce dependency on welfare services; and (3) Social Development: To support local access to, and coordination of, services and programs which safeguard the health and well-being of Native Americans. These goals are based on the premise that the local Native American community has the primary responsibility for determining its own needs, for planning and implementing its own programs, and for building an economic base from its own natural, physical, and human resources.

The Administration for Native Americans' funding policy is to assist Indian Tribes and Native American organizations to plan and implement their own long-term strategies for social and economic development. This funding approach moves the focus from increasing dependency on social services to increasing the productivity of both individuals and communities.

Funding is based on the competitive selection of applications submitted by Indian Tribes, Alaska Native Villages, and other Native American organizations representing American Indians, Alaskan Natives, Native Hawaiians, or Pacific Islanders. Panels of outside individuals review and rate all applications according to published criteria and seek to identify proposals most likely to produce permanent, beneficial change for Native American communities. Applicants must state specific, measurable goals based on the developmental needs of the community. Upon completion of the project grantees must report their accomplishments. Anticipated results include economic development through new business development and job creation, improved organizational effectiveness, new linkages with the private sector economy, remediation of environmental problems causing economic harm, and improved coordination of Federal and non-Federal resources to meet human needs in a developing economy.

Over 550 federally recognized Tribes including over 220 Alaska Native tribal governments, and about 250 Tribes that are either State-recognized or seeking Federal recognition. All Indian and Alaska Native organizations, Native Hawaiian communities, and Native populations in Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands are eligible for ANA programs. This includes non-federally recognized Tribes, Urban Indian Centers, small communities in rural areas of Alaska and the Pacific Basin, along with many others such as Alaska Native villages, multi-purpose community-based Indian organizations, and consortia.

Funding for the Native American Programs during the last five years has been as follows:

1999	\$34,857,879
2000	\$35,414,357
2001	\$45,989,000
2002	\$45,826,000
2003	\$45,196,000

Rationale for the Budget Request

The FY 2004 request for Native American Programs is \$45,119,000, which is \$77,000 less than the FY 2003 President's budget. The Native American programs will emphasize self-sufficiency through economic development and governance projects that will develop stable local diversified economies, job creation and entrepreneurship and lead to individual and tribal self-sufficiency. FY 2004 funds will be used to support activities that cover a wide range of interrelated governance and social and economic development efforts. Such activities include expansion and creation of businesses and jobs in many areas, e.g., technology development, tourism, specialty agriculture, arts and crafts, cultural centers, light manufacturing, health care systems, housing, fishing, and fish resources.

In FY 2004, grants made under the Native American Languages Program will ensure the preservation and enhancement of Native American language programs through: (a) community-based programs that bring older and younger Native Americans together to facilitate then transfer Native American languages; (b) training Native Americans to teach, interpret, or translate Native American languages; (c) developing, printing and disseminating materials to be used for teaching purposes; (d) training Native Americans to produce or participate in media

broadcasts in Native American languages; and compiling, recording and preserving Native American languages. These projects will support and encourage Tribal elders to work as mentors with youth and children, such as, teaching culture and language in Head Start and other child care programs.

Environmental quality has a direct impact on the ability of a Native American community to develop economic and social self-sufficiency. In FY 2004, grants made under the Indian Environmental Regulatory Enhancement Act will enable tribes to plan, develop and implement programs designed to improve their capacity to regulate environmental quality on Indian lands, in accordance with Federal and tribal laws and regulations.

Resource and Program Data
Native American Programs

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary ¹	\$41,125,446	\$40,371,000	\$40,371,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	2,958,716	2,525,000	2,525,000
Program Support ²	1,689,160	2,300,000	2,223,000
Total, Resources	\$45,773,322	\$45,196,000	\$45,119,000
Program Data:			
Number of Grants	285	245	245
New Starts:			
#	180	133	137
\$	\$25,478,290	\$18,286,574	\$20,403,089
Continuations:			
#	105	112	108
\$	\$15,647,156	\$22,084,426	\$19,967,911
Contracts:			
#	9	7	7
\$	\$2,958,716	\$3,825,000	\$3,748,000
Interagency Agreements:			
#	9	6	6
\$	\$1,689,160	\$1,000,000	\$1,000,000

¹ Includes funding for \$750,000 in Congressional earmarks.

² Includes funding for information technology support, contract fees and interagency agreements.

SOCIAL SERVICES RESEARCH AND DEMONSTRATION

Authorizing Legislation -- Sections 1110, 413(h) and 429A of the Social Security Act.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$30,918,000	\$6,000,000	\$5,982,000	-\$18,000

2004 Authorization....Such sums.

Purpose and Method of Operation

Social Services Research and Demonstration funds support cutting-edge research and evaluation projects in areas of critical national interest. Specifically, Social Services Research and Demonstration funds address the ACF's goals of: 1) increased stability and economic independence for American families; 2) improved healthy development of children and youth; and 3) services that are more effective, cost less, and respond better to customer needs.

Projects are conducted through grants, contracts, and cooperative agreements. Evaluation results, policy implications, and data from projects are disseminated to other Federal agencies, states, Congress, researchers and others through publications (including final reports and information memoranda), the Internet, conferences, and workshops. For example, in 2001-2002, evaluations and projects were funded exploring topics such as: welfare-to-work strategies for the hard-to-employ; programs to strengthen family relationships and promote healthy marriage; state and local implementation of activities related to the family formation goals of PRWORA; and continuing State welfare reform efforts.

Funding for the Social Services Research and Demonstration during the last five years has been as follows:

1999	\$26,880,000
2000	\$27,491,000
2001	\$38,096,000
2002	\$30,918,000
2003	\$6,000,000

The Administration for Children and Families benefited from its participation in the deliberations of the Research Coordination Council (RCC) in coordinating its research activities across the Department for Fiscal Year 2004. The discussions throughout demonstrated several overlapping areas of focus and concern among the Department's programs and identified new opportunities

for collaboration and joint funding among OPDIVs. Such collaboration and coordination could help bolster the "one Department" concept.

In part through participation in the RCC, and particularly the Human Services Workgroup, ACF has worked to ensure that FY 2004 planned research, demonstration and evaluation activities align with the Secretary's and the President's priority areas. Through this process we were able to target initiatives towards departmental priority areas and identify gaps needing further consideration in future initiatives, including research on homeless individuals and families, non-health related research on low-income individuals with disabilities and examining the use of faith-based and community organizations. Overall, the opportunity to participate in the RCC has provided an efficient mechanism for the exchange of information among OPDIVs regarding agency research and evaluation initiatives that has begun to foster greater collaboration and better focus.

Research funding in ACF is included in several appropriation accounts, and is aligned with the Departmental research priorities listed below:

Research Priority:	FY 2004 Budget Request (\$ in 000s)
I. Working Toward Independence	44,800
II. Rallying the Armies of Compassion	4,600
III. No Child Left Behind	141,500
IV. Promoting Active Aging and Improving Long-term Care	
V. Protecting and Empowering Specific Populations	
VI. Helping the Uninsured and Increasing Access to Health Care	
VII. Realizing the Possibilities of 21 st Century Health Care	
VIII. Ensuring Our Homeland is Prepared to Respond to Health Emergencies	
IX. Understanding Health Differences and Disparities-Closing the Gaps	
X. Preventing Disease, Illnesses, and Injury	
XI. Agency-specific Priorities (Building Strong Families)	
Total RD&E	190,900

In addressing Research Priority I -- Working Toward Independence, ACF expects to continue to work closely with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in funding some projects jointly and providing funding support for others in areas of mutual interest. ACF has actively pursued collaboration with ASPE in the investigation of such issues as caseload decline, workforce participation, characteristics of leavers, etc., relating to welfare reform. Because of intense public interest in the debate that preceded the passage of welfare reform legislation, the operational results of welfare reform and findings from funded projects are important to the Administration and the Congress for policy making and reauthorization of legislation. In addition to collaboration within the Department in the funding of projects, ACF has also forged close ties with the Department of Labor and the Department of Agriculture in the investigation of issue areas of mutual interest.

Regarding Priority II, ACF recently solicited proposals for funding research and conducting studies related to social services provided by faith-based and community-based organizations in the implementation of agency's new Compassion Capital Fund program. The panelists were drawn from programs within the Department, other federal agencies, and public/private organizations. The Compassion Capital Fund focuses on the following priority areas: homelessness, hunger, at-risk children and youth, transition from welfare to work, or intensive rehabilitation services for those most in need such as addicts and prisoners. Since the priority areas cover a broad spectrum of programs offered by several federal agencies (e.g., HUD, DOL, DOE, etc.) and the activities under this program overlap the jurisdiction of several agencies, ACF expects to make innovative approaches for the study of these issues in cooperation with them. The Human Services Workgroup of the RCC recommended that it work with the Center for Faith Based and Community Based Initiatives to develop a strategy to ensure coordination of ACF's research agenda through the Compassionate Capital Fund with other agencies and their faith-based and community-based agendas.

Regarding Priority III, Welfare reform has particularly turned a spotlight on the well-being of children living in low-income households. Although the poverty rate among children has declined in recent years, there are children with multiple service needs who are not being served. There is a growing recognition that the child must serve as a focus of social services programs that cut across agencies. ACF expects to strengthen its ties with other OPDIVs such as NICHD and CDC and other federal agencies such as HUD and DOE to gain a better understanding of the characteristics and needs of children and explore the funding of joint projects.

ACF expects that a rich diversity of approaches and innovative funding mechanisms will most likely result in significant program improvements and efficiencies in conducting its RD&E activities in Fiscal Year 2004.

Rationale for the Budget Request

The FY 2004 budget request for Social Services Research and Demonstration funds is \$5,982,000. This request assumes separate full funding for research and evaluation activities specified and pre-appropriated in the proposed reauthorization of the Temporary Assistance for Needy Families (TANF) program and related provisions of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).

There is continuing interest and need for sound research to help guide state and local efforts to help low-income families become and remain economically self-sufficient and to strengthen families. The changes brought about by PRWORA are unprecedented and create many new opportunities as well as many new challenges. ACF will make careful, strategic decisions regarding the allocation of resources to continue important work already begun and address the most pressing new areas needing support. Substantial efforts are needed to develop and provide states with credible information in making decisions in all areas of welfare reform, in order to promote sound and effective policy and program decisions particularly in areas where experience and knowledge are limited (e.g., working with individuals with multiple barriers, promoting healthy marriages, promoting sustained employment and advancement).

Serious questions remain to be studied and more are arising given the profound transformations underway. Program evaluations will continue to be designed to inform national and state policy and to provide timely feedback to states and communities. They will include both descriptive and impact studies of welfare reform interventions on low-income families' employment and economic well-being, positive family functioning and marriage, and children's well-being. Important areas will be addressed by continuing existing work and through new projects.

ACF will supplement our important current investments by addressing other important areas such as child care, child welfare, and systems improvements. The objective is to build effective strategies to meet the TANF family formation goals and address other vitally important areas. Some of the additional work will build upon numerous studies that confirm the concern that levels of child abuse and neglect remain high and that cases coming to public child welfare agencies are more complex and difficult to manage. Further, additional research is needed to help states and communities design programs to work more effectively with multi-problem families. Complementary studies are needed on structural decision-making and system dynamics; capacity building to promote policy and practice-based research; and sub-populations of children (e.g., infants and very young children). The various efforts to help create a complete picture of public assistance and family and child well-being outcomes must include mechanisms to collect accurate data from states. Accordingly, ACF will work with states to improve quality and linkages of administrative data and with Census and other organizations to ensure national surveys address these issues.

In addition, ACF will be working with funds provided by CDC to implement a positive youth development initiative. At least 25 percent of adolescents in the United States are at serious risk of not achieving a "productive adulthood" and face such risks as substance abuse, adolescent pregnancy, school failure, and involvement with the juvenile justice system. This prevention effort is designed to reduce risk behaviors by promoting healthy lifestyle choices and to build youth strengths and competencies. While risk reduction is one piece of the initiative, it is the building of assets, providing opportunity, and focusing on a healthy lifestyle that sets this innovative effort apart. A healthy lifestyle does not just mean avoiding bad habits and behaviors, but also engagement in positive activities and connections to peers, family, schools, and communities.

Positive interactions and coordination between and among multiple agencies working with vulnerable children and families is vital. We will seek input from many sources to help guide our decisions about how best to use the resources available to select among the many important areas needing new investments while continuing to support the important work already begun.

Resource and Program Data
Section 1110 – Social Services Research and Demonstration

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation	\$25,161,377	\$5,174,000	\$5,174,000
Demonstration/Development	2,550,000	500,000	500,000
Training/Technical Assistance	1,925,000	200,000	200,000
Program Support ¹	1,281,350	126,000	108,000
Total, Resources	\$30,917,727	\$6,000,000	\$5,982,000
<u>Program Data:</u>			
Number of Grants	21	10	10
New Starts:			
#	6	3	3
\$	\$2,000,000	\$1,850,000	\$1,832,000
Continuations:			
#	15	8	8
\$	\$2,257,242	\$3,000,000	\$3,000,000
Contracts:			
#	29	2	2
\$	\$26,510,085	\$1,000,000	\$1,000,000
Interagency Agreements:			
#	6	1	1
\$	\$150,400	\$150,000	\$150,000

¹ Includes funding for information technology support, conference fees and printing costs.

COMPASSION CAPITAL FUND

Authorizing Legislation – Section 1110 of the Social Security Act.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$29,949,000	\$100,000,000	\$100,000,000	\$0

2004 Authorization....Such sums.

Purpose and Method of Operation

The Administration is committed to ensuring that the Federal government plays a larger role in providing support to charitable organizations. Successful support for those in need can come from many sources, and we must broaden our efforts to work with faith-based and community-based organizations. These organizations are closest to the people in need; they have a stake in the community and have a history of providing services to those in need. In order to build upon the efforts of charitable organizations, this initiative provides funds to public/private partnerships to support charitable organizations in expanding or emulating model social service programs. These capacity-building entities are responsible for obtaining private matching funds as well as assisting community and faith-based organizations in seeking private funds.

The Compassion Capital Fund supports and promotes research on "best practices" among charitable organizations. Funds are used to assess and document successful models that could be emulated or expanded by entities that are recipients of the Compassion Capital Fund.

Funding for the Compassion Capital Fund program during the past two years has been as follows:

2002.....	\$29,949,000
2003.....	\$100,000,000

Rationale for the Budget Request

The FY 2004 President's Budget for the Compassion Capital Fund is \$100,000,000, the same as the FY 2003 President's Budget. These funds will be used to expand the number of public and private partnerships engaged in this critical effort and to identify successful models for providing social services by charitable organizations located in the communities -- closest to the people in need.

Resource and Program Data
Compassion Capital Fund

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation	\$2,217,159	\$1,500,000	\$1,500,000
Demonstration/Development	24,773,117	94,000,000	94,000,000
Training/Technical Assistance	2,195,001	2,295,059	2,295,059
Program Support ¹	727,815	2,204,941	2,204,941
Total, Resources	\$29,913,092	\$100,000,000	\$100,000,000
<u>Program Data:</u>			
Number of Grants	25	81	81
New Starts:			
#	25	60	
\$	\$25,631,926	\$69,226,883	
Continuations:			
#		21	81
\$		\$24,773,117	\$94,000,000
Contracts:			
#	3	3	3
\$	\$4,281,166	\$6,000,000	\$6,000,000
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support and grant/panel reviews.

PROMOTION AND SUPPORT OF RESPONSIBLE FATHERHOOD AND HEALTHY MARRIAGE

Legislation proposed in the FY 2003 President's Budget.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$0	\$20,000,000	\$20,000,000	\$0

FY 2004 Authorization.....\$20,000,000 (as proposed in the President's FY 2003 budget request pending Congressional action).

Purpose and Method of Operation

This Administration is committed to making responsible fatherhood and healthy marriage national priorities. Nearly 25 million children in the United States are growing up in homes without fathers. These children face a greater chance of living in poverty, performing poorly in school, and developing emotional and behavioral problems.

To reverse the rise in father absence and improve the well being of our Nation's children, this program will promote and support involved, committed, and responsible fatherhood, and encourage the formation and stability of healthy marriages. Funding will allow public entities and nonprofit community entities, including faith-based and Indian tribes and tribal organizations, to design demonstration service projects and activities to test promising approaches to improve outcomes for children by encouraging and supporting healthy marriages and responsible fatherhood. These approaches may include efforts to promote responsible, caring and effective parenting; enhance the abilities of unemployed or low-income fathers to provide material support for their families; and improve the ability of parents to effectively manage family business affairs. The outcomes for children with respect to such measures as increased family income, improved school performance, better health and a reduction in delinquency among others will help encourage and facilitate the replication of effective approaches to accomplishing these objectives.

In addition, funds may be used for grants to two multicity, multistate projects demonstrating promising approaches to promoting responsible, committed and involved fatherhood and healthy marriages. One of the projects would test the use of married couples to deliver program services. The funds also may be used to support projects of national significance relating to fatherhood promotion, including collection and dissemination of information, public education campaigns, and technical assistance.

Rationale for Budget Request

The FY 2004 budget request is \$20,000,000, the same amount as the FY 2003 President's Budget request. This funding will continue to spur increased State and community level approaches to assist fathers to be more actively and productively involved in the lives of their children.

Resource and Program Data
Promotion and Support of Responsible Fatherhood

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary		\$17,000,000	\$17,000,000
Research/Evaluation		950,000	950,000
Demonstration/Development		2,000,000	2,000,000
Training/Technical Assistance			
Program Support ¹		50,000	50,000
Total, Resources		\$20,000,000	\$20,000,000
Program Data:			
Number of Grants		30	30
New Starts:			
#		30	
\$		\$17,000,000	
Continuations:			
#			30
\$			\$17,000,000
Contracts:			
#		5	5
\$		\$2,950,000	\$2,950,000
Interagency Agreements:			
#			
\$			

¹ This includes funding for panel reviews and conference fees.

COMMUNITY SERVICES BLOCK GRANT

Authorizing Legislation – Legislation is proposed to reauthorize Section 674 (a) of the Community Services Block Grant Act.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$649,967,000	\$570,000,000	\$494,964,000	-\$75,036,000

2004 Authorization....\$494,964,000 (proposed in reauthorization).

Purpose and Method of Operation

The Community Services Block Grant program provides grants to States, territories and Indian Tribes to provide services and activities to reduce poverty, including services to address employment, education, better use of available income, housing assistance, nutrition, energy, emergency services, health, and substance abuse needs. Each State submits an annual application and certifies that the State agrees to provide: (1) a range of services and activities having a measurable and potentially major impact on causes of poverty in communities where poverty is an acute problem; and (2) activities designed to assist low-income participants, including the elderly, to become self-sufficient.

Funds are allocated to 50 States and the District of Columbia, Puerto Rico, Guam, American Samoa, the Virgin Islands, the Northern Marianas, and State- and federally-recognized Indian Tribes. Allocations are based on relative percentages of 1981 funding levels under Section 221 of the Economic Opportunity Act of 1964 as amended. The Community Services Block Grant Act requires States to pass through 90 percent of the Federal funds allocated to eligible entities, which in most cases are Community Action Agencies (CAAs).

Funding for the Community Services Block Grant during the past five years has been as follows:

1999.....	\$499,828,821
2000.....	\$527,615,000
2001.....	\$599,991,000
2002.....	\$649,967,000
2003.....	\$570,000,000

Rationale for the Budget Request

The FY 2004 President's Budget proposes to reauthorize the Community Services Block Grant with a funding level of \$494,964,000, a reduction of \$75,036,000 from the FY 2003 President's Budget. The budget request for FY 2004 reflects a lack of strong performance data for the

CSBG program. In the 2004 reauthorization of the CSBG statute, the Administration proposes to require that all states develop consistently applied performance measures to ensure that all CAAs and other agencies administering CSBG can assess their program outcomes, and are accountable for the services supported by the program. Organizations, including those historically designated CAAs that are not found to be performing at an acceptable performance target may lose their designation as a service provider for CSBG if acceptable corrections are not made. A state-run competition will be held to designate a new CAA to replace the agency that fails to meet acceptable standards. Faith-based organizations, as well as other non-governmental community organizations, will be eligible to apply for funding under the proposed revised authority.

Resource and Program Data
Community Services Block Grant

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$639,739,745	\$560,952,330	\$487,170,915
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	7,057,500	6,872,443	5,653,858
Program Support ¹	3,160,731	2,175,227	2,139,227
Total, Resources	\$649,957,976	\$570,000,000	\$494,964,000
Program Data:			
Number of Grantees	230	203	166
New Starts:			
#	174	148	159
\$	\$642,649,536	\$562,140,409	\$489,344,670
Continuations:			
#	56	55	7
\$	\$3,954,364	\$4,234,364	\$1,850,000
Contracts:			
#	16	6	7
\$	\$1,482,683	\$1,952,370	\$1,978,887
Interagency Agreements:			
#	8	1	1
\$	\$678,900	\$200,000	\$250,000

¹ Includes funding for grant/panel reviews and staff support and associated overhead costs.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Community Services Block Grant (CFDA #93.569)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$11,863,397	\$10,402,355	\$9,034,146	-\$1,368,210
Alaska	2,500,855	2,192,861	1,904,437	-288,425
Arizona	5,282,219	4,631,685	4,022,485	-609,200
Arkansas	8,796,789	7,713,417	6,698,880	-1,014,537
California	57,691,142	50,586,165	43,932,625	-6,653,540
Colorado	5,619,133	4,927,106	4,279,050	-648,057
Connecticut	7,803,603	6,842,547	5,942,555	-899,992
Delaware	3,420,085	2,998,883	2,604,443	-394,440
District of Columbia	10,628,939	9,319,928	8,094,088	-1,225,839
Florida	18,802,673	16,487,022	14,318,503	-2,168,519
Georgia	17,402,343	15,259,150	13,252,132	-2,007,018
Hawaii	3,420,085	2,998,883	2,604,443	-394,440
Idaho	3,360,528	2,946,661	2,559,090	-387,571
Illinois	30,560,513	26,796,820	23,272,265	-3,524,555
Indiana	9,419,843	8,259,738	7,173,344	-1,086,394
Iowa	7,001,652	6,139,361	5,331,858	-807,503
Kansas	5,280,229	4,629,940	4,020,969	-608,971
Kentucky	10,906,537	9,563,338	8,305,483	-1,257,855
Louisiana	15,187,724	13,317,274	11,565,668	-1,751,606
Maine	3,417,014	2,996,190	2,602,105	-394,085
Maryland	8,876,984	7,783,735	6,759,950	-1,023,786
Massachusetts	16,125,390	14,139,461	12,279,714	-1,859,747
Michigan	23,960,398	21,009,545	18,246,184	-2,763,361
Minnesota	7,785,096	6,826,319	5,928,461	-897,858
Mississippi	10,289,652	9,022,426	7,835,716	-1,186,709
Missouri	17,902,020	15,697,289	13,632,643	-2,064,646
Montana	3,201,394	2,807,125	2,437,907	-369,218
Nebraska	4,509,434	3,954,073	3,433,998	-520,075
Nevada	3,420,085	2,998,883	2,604,443	-394,440
New Hampshire	3,420,085	2,998,883	2,604,443	-394,440
New Jersey	17,701,412	15,521,387	13,479,877	-2,041,510
New Mexico	3,631,397	3,184,171	2,765,360	-418,810
New York	56,148,927	49,233,882	42,758,207	-6,475,676
North Carolina	16,963,303	14,874,180	12,917,797	-1,956,384
North Dakota	3,203,898	2,809,321	2,439,814	-369,507

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	25,218,283	22,112,515	19,204,081	-2,908,434
Oklahoma	8,101,537	7,103,789	6,169,436	-934,353
Oregon	5,158,324	4,523,048	3,928,137	-594,911
Pennsylvania	27,389,721	24,016,528	20,857,662	-3,158,866
Rhode Island	3,576,262	3,135,826	2,723,374	-412,452
South Carolina	9,950,365	8,724,924	7,577,344	-1,147,579
South Dakota	3,091,477	2,710,745	2,354,204	-356,541
Tennessee	12,744,857	11,175,259	9,705,390	-1,469,869
Texas	31,152,723	27,316,096	23,723,242	-3,592,855
Utah	3,342,244	2,930,629	2,545,166	-385,462
Vermont	3,420,085	2,998,883	2,604,443	-394,440
Virginia	10,357,509	9,081,926	7,887,390	-1,194,535
Washington	7,618,168	6,679,949	5,801,343	-878,606
West Virginia	7,242,237	6,350,316	5,515,066	-835,250
Wisconsin	7,871,460	6,902,047	5,994,229	-907,818
Wyoming	3,420,085	2,998,883	2,604,443	-394,440
Subtotal	605,160,115	530,631,369	460,838,035	-69,793,334
Tribes	3,905,539	3,424,551	2,974,123	-450,427
American Samoa	889,110	779,611	677,070	-102,541
Guam	841,474	737,842	640,794	-97,047
Northern Mariana Islands	527,143	462,222	401,427	-60,796
Puerto Rico	27,254,006	23,897,528	20,754,313	-3,143,214
Virgin Islands	1,162,358	1,019,207	885,152	-134,055
Subtotal	34,579,630	30,320,961	26,332,880	-3,988,081
Total States/Territories	639,739,745	560,952,330	487,170,915	-73,781,415
Discretionary Funds	3,160,731	2,175,227	2,139,227	-36,000
Technical Assistance	7,057,500	6,872,443	5,653,858	-1,218,585
Subtotal adjustments	10,218,231	9,047,670	7,793,085	-1,254,585
TOTAL RESOURCES	\$649,957,976	\$570,000,000	\$494,964,000	-\$75,036,000

COMMUNITY SERVICES DISCRETIONARY ACTIVITIES

Authorizing Legislation – Legislation is proposed to reauthorize section 674(b)(3) and 680 of the Community Services Block Grant Act.

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
Community Economic Development	\$26,976,000	\$27,017,000	\$26,939,000	-\$78,000
Rural Community Facilities	7,000,000	6,161,000	0	-6,161,000
Total, BA	\$33,976,000	\$33,178,000	\$26,939,000	-\$6,239,000

2004 Authorization....\$26,939,000 (proposed in reauthorization).

Purpose and Method of Operation

Community Services Discretionary grants are provided to private, locally-initiated community development corporations which sponsor enterprises providing employment, training, and business development opportunities for low-income residents; to public and private non-profit agencies for activities benefiting migrant and seasonal farm workers; and to public and private organizations to carry out programs in rural housing and community facilities development.

Rationale for the Budget Request

The FY 2004 President's Budget request for the Community Economic Development program is \$26,939,000, a reduction of \$78,000 from the FY 2003 President's Budget. As part of its reauthorization package, the Administration proposes to expand the pool of applicants in this program by redefining the eligible entities that may receive funding to include not only community development corporations as designated by grandfathered statutes, but to embrace other private, faith-based and community-based organizations.

Based on previous program results, it is anticipated that approximately 70 grants will be awarded resulting in approximately 70 new businesses being started or expanded, and more than 2,200 people being employed in full-time permanent jobs.

The FY 2004 request for the Rural Community Facilities program is zero, a reduction of \$6,161,000 from the FY 2003 President's Budget. The social services provided under this program are redundant with similar programs currently provided through the Environmental Protection Agency Rural Community Assistance Program, the Department of Agricultural Rural Development programs, and the Department of Housing and Urban Development. The

authorization for this program expires at the end of FY 2003. The Administration is not requesting reauthorization.

Resource and Program Data
Community Economic Development

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$24,729,699	\$23,380,720	\$23,282,357
Research/Evaluation	772,253	800,000	800,000
Demonstration/Development	250,000	800,000	800,000
Training/Technical Assistance	399,830	270,000	269,393
Program Support ¹	824,218	1,766,280	1,787,250
Total, Resources	\$26,976,000	\$27,017,000	\$26,939,000
Program Data:			
Number of Grants	86	70	70
New Starts:			
#	86	51	55
\$	\$24,729,699	\$15,231,460	\$15,151,750
Continuations:			
#		19	15
\$		\$8,419,260	\$8,400,000
Contracts:			
#	2	7	7
\$	\$1,683,011	\$3,366,280 ²	\$3,387,250
Interagency Agreements:			
#	3		
\$	\$563,290	³	

¹ Includes funding for information technology support, grant/panel reviews and printing costs.

² The increase is due to the shift of doing business with the Department of Interior's contracting office, Gov. Works from an interagency agreement to a purchase order requisition.

³ The decrease is due to the shift of doing business with Department of Interior's contracting office, Gov. Works from an interagency agreement to a purchase order requisition.

Resource and Program Data
Rural Community Facilities

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$6,572,471	\$5,731,000	
Research/Evaluation	396,585	385,000	
Demonstration/Development			
Training/Technical Assistance			
Program Support ¹	30,944	45,000	
Total, Resources	\$7,000,000	\$6,161,000	
Program Data:			
Number of Grants	7	7	
New Starts:			
#	7		
\$	\$6,572,471		
Continuations:			
#		7	
\$		\$5,731,000	
Contracts:			
#	2	2	
\$	\$400,000	\$430,000	
Interagency Agreements:			
#	2		
\$	\$27,529	2	

¹ Includes funding for information technology support and grant/panel reviews.

² The decrease is due to the shift of doing business with Department of Interior's contracting office, Gov. Works from an interagency agreement to a purchase order requisition.

JOB OPPORTUNITIES FOR LOW-INCOME INDIVIDUALS (JOLI)

Authorizing Legislation – Title V, Section 505 of the Family Support Act of 1998, P. L. 100-485 and Section 112 of the Personal Responsibility and Work Opportunity Reconciliation Act 1996, P. L. 104-193, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$5,500,000	\$5,500,000	\$5,497,000	-\$3,000

2004 Authorization ...\$25,000,000.

Purpose and Method of Operation

The Job Opportunities for Low-Income Individuals program provides grants on a competitive basis to non-profit organizations to create new employment and business opportunities for TANF recipients, and other low-income individuals through projects that include self-employment, micro-enterprise, expansion of existing businesses, new business ventures and strategies of developing or creating new jobs or employment opportunities.

Funding for the Job Opportunities for Low-Income Individuals program during the past five years has been as follows:

1999.....	\$5,500,000
2000.....	\$5,500,000
2001.....	\$5,500,000
2002.....	\$5,500,000
2003.....	\$5,500,000

Rationale for the Budget Request

The FY 2004 request for the Job Opportunities for Low-Income Individuals (JOLI) program is \$5,497,000, a reduction of \$3,000 from the FY 2003 President's Budget. Based on previous program results, it is anticipated that 7 grants will be awarded. These grants will create approximately 650 jobs for TANF recipients and other low-income individuals whose income does not exceed 100 percent of the official poverty guidelines. Grants are made to nonprofit 501(c)(3) or (4) organizations to develop job creation projects through self-employment, micro-enterprise and new business ventures. Grants also may be made for technical and financial assistance to private employers in the community that will result in the creation of full-time permanent jobs for the eligible program participants.

Resource and Program Data
Job Opportunities for Low-Income Individuals (JOLI)

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary	\$4,466,756	\$3,986,779	\$3,986,779
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	545,000	650,000	650,000
Program Support ¹	488,244	863,221	860,221
Total, Resources	\$5,500,000	\$5,500,000	\$5,497,000
<u>Program Data:</u>			
Number of Grants	7	7	7
New Starts:			
#	7	7	7
\$	\$4,466,756	\$3,986,779	\$3,986,779
Continuations:			
#			
\$			
Contracts:			
#	1	6	6
\$	\$545,000	\$1,513,221 ²	\$1,510,221
Interagency Agreements:			
#	2		
\$	\$488,244		

¹ Includes funding for information technology support, grant/panel reviews, conferences and printing.

² The shift is due to changing an IAA w/the Department of Interior's contracting office, Gov. Works to a purchase order requisition.

NATIONAL YOUTH SPORTS

Authorizing Legislation – Section 682 of the Community Services Block Grant Act. Legislation expires on September 30, 2003.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$17,000,000	\$0	\$0	\$0

2004 Authorization.....\$0 (reauthorization not requested).

Purpose and Method of Operation

The National Youth Sports program issues a grant to an eligible service provider to administer national or regional programs to provide instructional activities for low-income youth.

Funding for the National Youth Sports program during the past five years has been as follows:

1999.....	\$15,000,000
2000.....	\$15,000,000
2001.....	\$16,000,000
2002.....	\$17,000,000
2003.....	\$0

Rationale for the Budget Request

The FY 2004 request for the National Youth Sports program is zero, the same as the FY 2003 President's Budget. States can provide similar services with greater flexibility through use of the Community Services Block Grant funds. This program expires at the end of 2003. The Administration is not seeking reauthorization.

Resource and Program Data
National Youth Sports

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary	\$17,000,000		
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$17,000,000		
<u>Program Data:</u>			
Number of Grants	1		
New Starts:			
#			
\$			
Continuations:			
#	1		
\$	\$17,000,000		
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

COMMUNITY FOOD AND NUTRITION

Authorizing Legislation – Section 681 of the Community Services Block Grant Act.
 Legislation expires on September 30, 2003.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$7,312,000	\$6,657,000	\$0	-\$6,657,000

2004 Authorization....\$0 (reauthorization not requested).

Purpose and Method of Operation

The Community Food and Nutrition program provides grants to public and private agencies at the local and State level to: (1) coordinate existing food assistance resources; (2) assist in identifying sponsors of child nutrition programs and initiating new programs in under-served and unserved areas; and (3) develop innovative approaches at the State and local level to meet the nutrition needs of low-income people.

The authorizing legislation mandates that 60 percent of the amount appropriated, up to \$6,000,000, is to be allocated to States for statewide programs and 40 percent is to be awarded on a competitive basis. Under current law, amounts appropriated in excess of \$6,000,000 are allotted as followed: (1) 40 percent of such excess is to be allotted to eligible agencies for statewide grants; (2) 40 percent of such excess is to be awarded on a competitive basis for local and statewide programs; and (3) 20 percent of such excess is to be awarded on a competitive basis for nationwide programs, including programs benefiting Native Americans and migrant farm workers. The authorizing legislation for this program expires at the end of Fiscal Year 2003.

Funding for the Community Food and Nutrition program during the past five years has been as follows:

1999.....	\$4,997,215
2000.....	\$6,315,000
2001.....	\$6,314,000
2002.....	\$7,312,000
2003.....	\$6,657,000

Rationale for the Budget Request

The FY 2004 request for Community Food and Nutrition program is zero, a reduction of \$6,657,000 from the FY 2003 President's Budget. States currently receive similar assistance

through programs housed within the Department of Agriculture Food and Nutrition Service. This program's legislative authority expires at the end of 2003. The Administration is not seeking reauthorization.

Resource and Program Data
Community Food and Nutrition

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$4,125,600	\$3,862,800	
Discretionary	2,623,045	1,891,071	
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support ¹	562,495	903,129	
Total, Resources	\$7,311,140	\$6,657,000	
<u>Program Data:</u>			
Number of Grants	100	90	
New Starts:			
#	100	89	
\$	\$6,748,645	\$5,622,471	
Continuations:			
#		1	
\$		\$131,400	
Contracts:			
#	1	4	
\$	\$1,019	\$903,129	
Interagency Agreements:			
#	2		
\$	\$561,476		

¹ Includes funding for information technology support, grant/panel reviews and printing.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Community Food and Nutrition (CFDA #93.571)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$86,281	\$80,785	\$0	-\$80,785
Alaska	15,000	14,045	0	-14,045
Arizona	56,222	52,641	0	-52,641
Arkansas	51,870	48,566	0	-48,566
California	485,404	454,484	0	-454,484
Colorado	50,874	47,633	0	-47,633
Connecticut	22,011	20,609	0	-20,609
Delaware	15,000	14,045	0	-14,045
District of Columbia	15,000	14,045	0	-14,045
Florida	213,425	199,830	0	-199,830
Georgia	112,455	105,292	0	-105,292
Hawaii	15,000	14,045	0	-14,045
Idaho	18,993	17,783	0	-17,783
Illinois	188,676	176,657	0	-176,657
Indiana	79,538	74,471	0	-74,471
Iowa	32,658	30,578	0	-30,578
Kansas	30,417	28,479	0	-28,479
Kentucky	69,907	65,454	0	-65,454
Louisiana	105,582	98,856	0	-98,856
Maine	17,898	16,758	0	-16,758
Maryland	56,033	52,464	0	-52,464
Massachusetts	68,991	64,596	0	-64,596
Michigan	148,379	138,927	0	-138,927
Minnesota	59,838	56,026	0	-56,026
Mississippi	73,761	69,062	0	-69,062
Missouri	79,299	74,248	0	-74,248
Montana	15,657	14,660	0	-14,660
Nebraska	18,903	17,699	0	-17,699
Nevada	15,806	14,799	0	-14,799
New Hampshire	15,000	14,045	0	-14,045
New Jersey	85,554	80,104	0	-80,104
New Mexico	35,885	33,599	0	-33,599
New York	293,680	274,973	0	-274,973
North Carolina	96,649	90,492	0	-90,492
North Dakota	15,000	14,045	0	-14,045

*Administration for Children and Families
Justification of Estimates for Appropriations Committees*

*Page H-137
Children and Families Services Programs*

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	146,666	137,323	0	-137,323
Oklahoma	52,129	48,808	0	-48,808
Oregon	33,674	31,529	0	-31,529
Pennsylvania	154,833	144,970	0	-144,970
Rhode Island	15,000	14,045	0	-14,045
South Carolina	61,013	57,126	0	-57,126
South Dakota	15,000	14,045	0	-14,045
Tennessee	93,681	87,714	0	-87,714
Texas	302,246	282,993	0	-282,993
Utah	17,250	16,151	0	-16,151
Vermont	15,000	14,045	0	-14,045
Virginia	77,227	72,308	0	-72,308
Washington	58,304	54,590	0	-54,590
West Virginia	37,080	34,718	0	-34,718
Wisconsin	53,483	50,076	0	-50,076
Wyoming	15,000	14,045	0	-14,045
Subtotal	3,908,232	3,659,278	0	-3,659,278
Tribes	0	0	0	0
Migrant Program	0	0	0	0
American Samoa	1,970	1,845	0	-1,845
Guam	1,849	1,731	0	-1,731
Northern Mariana Islands	1,000	936	0	-936
Palau	0	0	0	0
Puerto Rico	209,083	195,764	0	-195,764
Virgin Islands	3,466	3,245	0	-3,245
Subtotal	217,368	203,522	0	-203,522
Total States/Territories	4,125,600	3,862,800	0	-3,862,800
Discretionary Funds	3,185,540	2,794,200	0	-2,794,200
Subtotal adjustments	3,185,540	2,794,200	0	-2,794,200
TOTAL RESOURCES	\$7,311,140	\$6,657,000	\$0	-\$6,657,000

INDIVIDUAL DEVELOPMENT ACCOUNTS

Authorizing Legislation – Legislation is proposed to reauthorize section 416 of the Assets for Independence Act, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$24,943,000	\$24,990,000	\$24,912,000	-\$78,000

2004 Authorization....\$25,000,000 (proposed in reauthorization).

Purpose and Method of Operation

The Individual Development Accounts (IDA) demonstration program will help determine: (1) the social, civic, psychological and economic effects of providing to individuals and families with limited means an incentive to accumulate assets by saving a portion of their earned income; (2) the extent to which an asset-based policy that promotes saving for post-secondary education, home ownership, and micro-enterprise development may be used to enable individuals and families with limited means to increase their economic self-sufficiency; and (3) the extent to which an asset-based policy stabilizes and improves families and the communities in which they live. This demonstration program supports the work that States and community-based organizations are doing in support of IDAs and other asset-based development strategies.

IDAs are dedicated savings accounts that can be used for purchasing a first home, paying for post secondary education, or capitalizing a business. These investments are associated with extremely high rates of return that have the potential to bring a new level of economic and personal security to families and communities. Participants are able to make emergency withdrawals in limited circumstances but must pay back such withdrawals within 12 months.

Non-profit 501(c)(3) organizations are eligible to apply for the funds as individual organizations or jointly. In addition, a State or local government agency, or a tribal government may submit an application jointly with one or more non-profit organizations. Collaboration with a financial institution or for-profit community development corporation is permitted. States that have made at least a \$1 million commitment (with non-Federal funds) to a statewide IDA program as of the date of enactment are eligible for direct funding from the Department of Health and Human Services. "Grandfathered" States do not have to comply with certain sections of the Act. The President's 2004 Budget requests reauthorization of the program including an amendment to include faith-based organizations in the definition of entities eligible to administer the program.

Applicants must raise private and public (non-federal) funds to receive a federal grant. The leveraging requirement is effectively 1:1 in that the federal grant cannot exceed the non-federal funds raised for the project, nor can federal matches into IDAs exceed the non-federal matches.

The maximum federal grant is \$1 million per year. The President's 2004 proposal seeks to raise this limit to \$2 million.

Funding for the Individual Development Accounts program during the past four years has been as follows:

2000.....	\$9,998,000
2001.....	\$24,891,000
2002.....	\$24,943,000
2003.....	\$24,990,000

Rationale for the Budget Request

The FY 2004 request for the Individual Development Accounts program is \$24,990,000, a reduction of \$78,000 from the FY 2003 President's Budget. This amount will fund an estimated 69 grants that will provide on-going support for the IDA program, thereby allowing additional low-income individuals and families to save money and increase economic self-sufficiency. Since the creation of this program in the 1998 Assets for Independence Act, more than 5,000 individual development accounts have opened and thousands of families are moving steadily toward accruing assets. The creation of this demonstration program was a significant step forward in exploring unique strategies to empower low-income Americans. The President's Budget seeks reauthorization of this demonstration program to examine the benefits of a matched asset-accumulation program in assisting economically disadvantaged families and communities move toward self sufficiency.

Resource and Program Data
Individual Development Accounts

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation	\$512,500	\$512,500	\$512,500
Demonstration/Development	21,040,988	20,404,248	20,673,222
Training/Technical Assistance	2,147,329	1,800,000	1,800,000
Program Support ¹	1,230,705	2,273,252 ²	1,926,278
Total, Resources	\$24,931,522	\$24,990,000	\$24,912,000
<u>Program Data:</u>			
Number of Grants	69	65	69
New Starts:			
#	67	63	67
\$	\$16,655,039	\$15,875,044	\$17,173,222
Continuations:			
#	2	2	2
\$	\$2,000,000	\$2,000,000	\$2,000,000
Contracts:			
#	6	9	9
\$	\$3,872,776	\$5,828,123 ³	\$4,601,616
Interagency Agreements:			
#	4	3	1
\$	\$2,003,546	\$483,608 ⁴	\$305,808

¹ Includes funding for information technology support, grant/panel reviews, contract/printing costs and staff support.

² The increase is an investment in building the program management and infrastructure of the IDA program. This strategy is designed to increase the quality and quantity of AFIA applicants and grantees.

³ The shift is due to changing an IAA w/the Department of Interior's contracting office, Gov. Works to a purchase order requisition.

⁴ The decrease is due to the shift of doing business with the Department of Interior's contracting office, Gov. Works from an interagency agreement to a purchase order requisition.

FAMILY VIOLENCE PREVENTION AND SERVICES/BATTERED WOMEN'S SHELTERS

Authorizing Legislation -- Section 310 of the Family Violence Prevention and Services Act, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$124,459,000	\$124,459,000	\$124,423,000	-\$36,000

FY 2004....\$175,000,000.

Purpose and Method of Operation

The Family Violence Prevention and Services program provides grants to States and Indian Tribes to assist in supporting programs and projects to prevent incidents of family violence, provide immediate shelter and related assistance for victims of family violence and their dependents and provide resources to programs that provide prevention services for perpetrators. These grants are made in support of the strategic goal of healthy, safe and supportive communities and tribes and the performance goal of building these healthy, safe and supportive communities to increase the ability of family violence victims to plan for safety.

By statute, 70 percent of Family Violence funds are awarded in grants to States and Territories. State grants are allocated based on the State's population. Grants to territories and insular areas are equal to one-eighth of one percent of the amounts available for grants for that fiscal year.

The Act specifies that a State may keep five percent of its allotment for administrative costs and must distribute the remaining funds to local public agencies and non-profit private organizations, including religious and charitable organizations and voluntary associations. Seventy percent of the funds must be used to provide immediate shelter and related assistance to victims of family violence and their dependents. Most States exceed the 70 percent requirement. States may use the remaining funds to: establish new shelters in under served areas; expand counseling, self-help, and substance abuse referral services; set up demonstrations programs, e.g., elder abuse shelters; or, provide training for staff and volunteers.

By statute, 10 percent of Family Violence funds are allocated for grants to Indian Tribes and tribal organizations. The amount of the Indian grants is based on the population of the tribe. Tribes use these funds primarily for emergency shelter and related assistance. These grants have assisted Tribes in focusing on and improving services to victims and their families. Some Tribes also have used these funds for public education efforts to break the patterns of family violence.

State Domestic Violence Coalitions receive 10 percent of the appropriation to further the purposes of domestic violence intervention and prevention. State Domestic Violence Coalitions

are membership organizations for all shelters in the State. The grants to the coalitions support their technical assistance efforts with their membership and other related services providers. The grants also support training and related collaborative efforts with other social services sectors, e.g. law enforcement, health, education and welfare.

The network of Information and Technical Assistance Centers (the National Resource Center and the Special Issue Resource Centers) receives five percent of the appropriation to provide information, technical assistance and training to Federal, State, Indian and local domestic violence agencies and other professionals and individuals in the field. The purpose of this network (a network of five domestic violence resource centers: National Resource Center on Domestic Violence; Resource Center on Civil and Criminal Law a.k.a. Battered Women's Justice Project; Health Resource Center on Domestic Violence; Resource Center on Child Protection and Custody; and Resource Center for Indian Tribes and Tribal Organizations) is to strengthen the existing support systems serving battered women, their children and other victims of domestic violence. The network also provides comprehensive information and resources, policy development, and technical assistance designed to enhance community response to and prevention of domestic violence.

The statute also authorizes funds for activities relating to the issue of family violence through grants, contracts or interagency agreements. Under this authority, grants were awarded to:

- Support collaborative efforts between faith based community/spiritual organizations and the domestic violence community that created additional points of entry for persons in abusive relationships as they seek services and more informed responses;
- Historical black colleges and universities, Hispanic-serving colleges and universities, and tribal colleges and universities to support social work graduate student practicums in domestic violence;
- Projects demonstrating protocols and training approaches that are useful to organizations and agencies providing services to immigrant and battered women. Projects between child protective service agencies and domestic violence advocacy organizations were supported to develop effective strategies for domestic violence services integration into child protection systems and strategies; and
- Domestic violence prevention service providers and advocacy organizations for public information and community awareness activities.

Funding for the Family Violence Prevention and Services program during the last five years has been as follows:

1999.....	\$88,778,000
2000.....	\$101,118,000
2001.....	\$116,899,000
2002.....	\$124,459,000
2003.....	\$124,459,000

Rationale for the Budget Request

The FY 2004 request for the Family Violence Prevention and Services Program is \$124,459,000, a reduction of \$36,000 from the FY 2003 President's Budget. Domestic violence disrupts communities, destroys relationships, and harms hundreds of thousands of Americans each year. In addition to the personal burdens domestic violence causes, the financial burdens, public and private, run into the billions of dollars each year. The additional funds will be used to increase the range of services, residential and non-residential, provided by shelters and increase the number of shelters funded by the grants for battered women's shelters. These funds will provide on-going support for the critical core services to individuals and families impacted by domestic violence.

Resource and Program Data
Family Violence/Grants for Battered Women's Shelters

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$112,013,100	\$112,013,100	\$111,980,700
Resource Centers	6,222,950	6,222,950	6,221,150
Discretionary	3,756,446	2,740,427	2,800,000
Research/Evaluation	330,567	650,000	600,000
Demonstration/Development	300,000	300,000	300,000
Training/Technical Assistance		1,000,000	1,000,000
Program Support ¹	1,835,937	1,532,523	1,521,150
Total, Resources	\$124,459,000	\$124,459,000	\$124,423,000
Program Data:			
Number of Grants	282	282	282
New Starts:			
#	272	272	272
\$	\$114,369,514	\$113,353,495	\$113,380,668
Continuations:			
#	10	10	10
\$	\$7,622,981	\$7,622,982	\$7,621,182
Contracts:			
#	4	5	5
\$	\$186,021	\$2,689,523 ²	\$2,678,150
Interagency Agreements:			
#	6	3	3
\$	\$2,280,484	\$793,000	\$743,000

¹ Includes funding for information technology support, grant/panel reviews and contract costs.

² The shift is due to changing an LAA w/the Department of Interior's contracting office, Gov. Works to a purchase order requisition.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Family Violence and Prevention Services (CFDA #93.592)

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$1,464,065	\$1,464,065	\$1,463,642	-\$423
Alaska	721,812	721,812	721,603	-209
Arizona	1,596,874	1,596,874	1,596,412	-462
Arkansas	1,119,438	1,119,438	1,119,114	-324
California	7,181,213	7,181,213	7,179,136	-2,077
Colorado	1,435,729	1,435,729	1,435,314	-415
Connecticut	1,261,696	1,261,696	1,261,331	-365
Delaware	752,252	752,252	752,034	-218
District of Columbia	711,150	711,150	710,944	-206
Florida	3,705,353	3,705,353	3,704,281	-1,072
Georgia	2,190,616	2,190,616	2,189,982	-634
Hawaii	835,400	835,400	835,158	-242
Idaho	851,413	851,413	851,167	-246
Illinois	3,013,051	3,013,051	3,012,179	-872
Indiana	1,781,430	1,781,430	1,780,915	-515
Iowa	1,168,581	1,168,581	1,168,243	-338
Kansas	1,122,356	1,122,356	1,122,031	-325
Kentucky	1,385,310	1,385,310	1,384,909	-401
Louisiana	1,468,316	1,468,316	1,467,891	-425
Maine	847,716	847,716	847,471	-245
Maryland	1,629,100	1,629,100	1,628,629	-471
Massachusetts	1,833,621	1,833,621	1,833,091	-530
Michigan	2,531,026	2,531,026	2,530,294	-732
Minnesota	1,555,848	1,555,848	1,555,398	-450
Mississippi	1,152,713	1,152,713	1,152,380	-333
Missouri	1,687,142	1,687,142	1,686,654	-488
Montana	775,295	775,295	775,071	-224
Nebraska	932,496	932,496	932,226	-270
Nevada	988,258	988,258	987,972	-286
New Hampshire	840,111	840,111	839,868	-243
New Jersey	2,234,896	2,234,896	2,234,250	-646
New Mexico	953,438	953,438	953,162	-276
New York	4,287,099	4,287,099	4,285,859	-1,240
North Carolina	2,163,970	2,163,970	2,163,344	-626
North Dakota	724,779	724,779	724,569	-210

STATE/TERRITORY	FY 2002 Actual	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	2,805,899	2,805,899	2,805,087	-812
Oklahoma	1,270,457	1,270,457	1,270,090	-367
Oregon	1,264,773	1,264,773	1,264,407	-366
Pennsylvania	2,986,191	2,986,191	2,985,327	-864
Rhode Island	803,687	803,687	803,455	-232
South Carolina	1,379,528	1,379,528	1,379,129	-399
South Dakota	746,665	746,665	746,449	-216
Tennessee	1,705,420	1,705,420	1,704,927	-493
Texas	4,651,479	4,651,479	4,650,134	-1,345
Utah	1,033,902	1,033,902	1,033,603	-299
Vermont	718,294	718,294	718,086	-208
Virginia	1,975,345	1,975,345	1,974,774	-571
Washington	1,745,219	1,745,219	1,744,714	-505
West Virginia	951,359	951,359	951,084	-275
Wisconsin	1,642,154	1,642,154	1,641,679	-475
Wyoming	695,941	695,941	695,740	-201
Subtotal	85,279,876	85,279,876	85,255,209	-24,667
Tribes	12,445,900	12,445,900	12,442,300	-3,600
American Samoa	124,459	124,459	124,423	-36
Guam	124,459	124,459	124,423	-36
Northern Mariana Islands	124,459	124,459	124,423	-36
Palau	0	0	0	0
Puerto Rico	1,343,588	1,343,588	1,343,199	-389
Virgin Islands	124,459	124,459	124,423	-36
Subtotal	14,287,324	14,287,324	14,283,191	-4,133
Total States/Territories	99,567,200	99,567,200	99,538,400	-28,800
Coalitions	12,445,900	12,445,900	12,442,300	-3,600
Resource Centers	6,222,950	6,222,950	6,221,150	-1,800
Discretionary Activities	6,222,950	6,222,950	6,221,150	-1,800
Subtotal adjustments	24,891,800	24,891,800	24,884,600	-7,200
TOTAL RESOURCES	\$124,459,000	\$124,459,000	\$124,423,000¹	-\$36,000

¹ A small reduction in the level of information technology support was taken in FY 2004 in a variety of discretionary accounts, including Family Violence and Prevention Services. Because the distribution of funds in Family Violence and Prevention Services is driven by formula, it was not possible to limit the impact solely to program support funding.

DOMESTIC VIOLENCE HOTLINE

Authorizing Legislation -- Section 316(f) of the Family Violence Prevention and Services Act, as amended.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase Or Decrease
\$2,157,000	\$2,157,000	\$3,000,000	+843,000

FY 2004....\$2,000,000.

Purpose and Method of Operation

The National Domestic Violence Hotline is a cooperative agreement which funds the operation of a national, toll-free telephone hotline to provide information and assistance to victims of domestic violence in an effort to build healthy, safe and supportive communities and tribes. Counseling and referral services are provided 24 hours-a-day, 365 days a year. The hotline also must publicize its telephone number and the services it provides to potential users throughout the United States.

A database is maintained that provides information on services for victims of domestic violence, including the availability of shelters, to which callers may be referred throughout the United States. Trained hotline counselors are available for non-English speakers and the hotline is accessible to persons who are hearing-impaired.

Funding for the Domestic Violence Hotline during the last five years has been as follows:

1999.....	\$1,200,000
2000.....	\$1,957,000
2001.....	\$2,157,000
2002.....	\$2,157,000
2003.....	\$2,157,000

Rationale for the Budget Request

The FY 2004 request for the Domestic Violence Hotline is \$3,000,000, an increase of \$843,000 over the FY 2003 President's Budget. The increase is intended to provide for more calls to be answered and to ensure that the Hotline is positioned to respond to a "spike" in calls as various broadcast and public awareness activities impact call numbers. The Hotline averages 300 to 400 calls a day. However, a public awareness message or a program that publicizes the Hotline will provide a "spike" of 400 to 500 within hours. The additional funding will also enable the Hotline to maintain its core number of advocates at 28 full and part-time staff, and approximately

20 relief, and 25 volunteer Hotline advocates. This staffing level assures the Hotline is answered 24 hours per day, 7 days a week. The additional funding will reduce the number of "dropped" calls and provide the Hotline with the ability to handle the projected increase of 1,500 to 2,000 calls per month. The hotline serves as a critical partner in the prevention and resource assistance efforts of the Domestic Violence Resource Network. It provides: crisis intervention by helping the caller identify problems and possible solutions, including making plans for safety in an emergency; information about sources of assistance for individuals and their friends, families, and employers wanting to learn more about domestic violence, child abuse, sexual assault, intervention programs for batterers, working through the criminal justice system, and related issues; and referrals to battered women's shelters and programs, social service agencies, legal programs, and other groups and organizations willing to help.

Resource and Program Data
Domestic Violence Hotline

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary	\$2,157,000	\$2,157,000	\$3,000,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$2,157,000	\$2,157,000	\$3,000,000
<u>Program Data:</u>			
Number of Grants	1	1	1
New Starts:			
#			
\$			
Continuations:			
#	1	1	1
\$	\$2,157,000	\$2,157,000	\$3,000,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

FEDERAL ADMINISTRATION

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
Federal Administration	\$171,466,000	\$171,837,000	\$179,584,000	+\$7,747,000
Center for Faith-Based and Community Initiatives	1,497,000	1,500,000	1,400,000	-100,000
Total, BA	\$172,963,000	\$173,337,000	\$180,984,000	+\$7,647,000
FTE ¹	1,465	1,512	1,472	-40

FY 2004 Authorization....Such sums.

Purpose and Method of Operation

The Federal Administration account includes funding for salaries and benefits and associated expenses of the Administration for Children and Families and the Department's Center for Faith Based and Community Initiatives. These resources allow ACF and the Center to maintain the staff and related program management and support activities necessary to effectively administer Federal programs that promote the economic and social well being of families, children, individuals and communities. ACF conducts operations at ACF Headquarters in Washington, D.C., in the ten regional offices of the Department of Health and Human Services (HHS) and at the thirteen audit offices of the Office of Child Support Enforcement in various locations throughout the Nation. More than half of all ACF employees work in Headquarters offices in the various program and staff offices. The remainder of the work force is in regional and field offices.

Appropriations for Federal Administration during the last five years are as follows:

<u>Year</u>	<u>Funding</u>	<u>FTE Usage</u>
1999	\$144,454,000	1,509
2000	\$147,908,000	1,470
2001	\$163,846,000	1,430
2002	\$172,963,000	1,465
2003	\$173,337,000	1,512

¹ The FY 2002 FTE figure includes 17 FTE for the Unaccompanied Alien Children (UAC) program which was transferred to ACF from the Immigration and Naturalization Service (INS) in FY 2003. Funding for these positions is included under the Refugee and Entrant Assistance account.

Rationale for the Budget Request

The FY 2004 budget request for Federal Administration is \$181.0 million, a net increase of \$7.6 million from the FY 2003 budget. This funding level would support 1,472 FTE, 40 FTE below the level requested in the FY 2003 President's Budget.

ACF's FY 2004 budget supports the President's Management Agenda, and includes cost savings from consolidating administrative functions, organizational layering to speed decision making processes, competitive sourcing, implementation of effective workforce planning and human capital management strategies, and adoption of other economies and efficiencies in administrative operations.

A specific example of our efforts is evidenced in our request for \$2 million to support the child welfare monitoring initiative. Under current child welfare monitoring regulations, the number of States to be reviewed increases as we return to States that have failed reviews as well as complete required follow-up reviews for States with program improvement plans. These funds will be used for contracts and related support expenditures in order to complete the reviews. This support is critical at a time when much attention is being focused on the outcomes of this important review process.

This budget request includes funding to support Departmental efforts to improve the HHS Information Technology Enterprise Infrastructure. The request includes funds to support an enterprise approach to investing in key information technology infrastructure such as security and network modernization. These investments will enable HHS programs to carry out their missions more securely and at a lower cost. Agency funds will be combined with resources in the Information Technology Security and Innovation Fund in the Office of the Secretary to promote collaboration in planning and project management and to achieve common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software.

Our budget request includes savings in the Information Technology (IT) Budget from ongoing IT consolidation efforts and additional reduced spending through the streamlining or elimination of lower priority projects. ACF is participating in the consolidation of Information Technology infrastructure support staff service across the eight smaller HHS Operating Divisions.

The Unified Financial Management System (UFMS) will be implemented in the Department to replace five legacy accounting systems currently used across the Operating Divisions. The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. It will also promote the consolidation of accounting operations and thereby reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable Agencies and program administrators to

make more timely and informed decisions regarding their operations. ACF requests \$1.632 million to support this effort in FY 2004.¹

Finally, as part of a government-wide effort to strengthen the focus on erroneous payments in programs funded by the Federal government, the Federal Administration request includes \$5 million to be targeted to our efforts in identifying and reducing erroneous payments. Three programs will be the focus of our efforts in FY 2004 – Temporary Assistance for Needy Families, Foster Care, and Head Start.

¹ These funds are reflected primarily in Federal Administration, but a portion of these costs is included in other discretionary accounts in ACF where information technology activities can be funded.

Detail of Full-Time Equivalent Employment (FTE)

	2002 <u>Actual</u> ¹	2003 <u>Estimate</u>	2004 <u>Estimate</u>
Administration for Children, Youth and Families	172	180	170
Office of Administration	129	142	137
Office of Child Support Enforcement	188	195	189
Office of Family Assistance.....	31	33	33
Office of Community Services.....	59	63	63
Office of Regional Operations.....	8	8	8
Office of Refugee Resettlement.....	46	50	50
Administration for Developmental Disabilities.....	23	22	22
Administration for Native Americans.....	10	11	11
Office of Public Affairs	12	12	12
Office of Planning, Research and Evaluation.....	32	32	32
Immediate Office of the Assistant Secretary.....	27	28	28
Office of Legislative Affairs and Budget.....	25	25	25
President's Committee on Mental Retardation.....	4	5	5
Regional Offices.....	<u>699</u>	<u>706</u>	<u>687</u>
Total, ACF.....	1,465	1,512	1,472

Average GS Grade

1999.....	12.2
2000.....	12.2
2001.....	12.5
2002.....	12.5
2003.....	12.5

¹ FY 2002 is shown comparably to reflect the transfer of the Unaccompanied Alien Children (UAC) program from the Immigration and Naturalization Service (INS) to the Office of Refugee Resettlement in FY 2003.

**Program Administration
Detail of Positions**

	2002 <u>Actual</u>	2003 <u>Estimate</u>	2004 <u>Estimate</u>
Executive Level I.....	0	0	0
Executive Level II.....	0	0	0
Executive Level III.....	0	0	0
Executive Level IV.....	2	2	2
Executive Level V.....	<u>0</u>	<u>1</u>	<u>1</u>
Subtotal.....	2	3	3
Total - Exec. Lev. Salary.....	\$260,000	\$390,450	\$399,301
ES-6.....	0	0	0
ES-5.....	0	0	0
ES-4.....	3	3	3
ES-3.....	4	4	4
ES-2.....	2	2	2
ES-1.....	<u>12</u>	<u>12</u>	<u>12</u>
Subtotal.....	21	21	21
Total - ES Salary.....	\$2,711,837	\$2,806,408	\$2,883,146
GS-15.....	142	142	138
GS-14.....	303	303	295
GS-13.....	552	550	534
GS-12.....	251	279	272
GS-11.....	52	54	53
GS-10.....	0	0	0
GS-9.....	47	58	56
GS-8.....	13	13	13
GS-7.....	34	40	39
GS-6.....	24	25	24
GS-5.....	9	9	9
GS-4.....	6	6	6
GS-3.....	3	3	3
GS-2.....	6	6	6
GS-1.....	<u>0</u>	<u>0</u>	<u>0</u>
Subtotal.....	1,442	1,488	1,448
Average ES level.....	1.9	1.9	1.9
Average ES salary.....	\$129,135	\$133,638	\$137,293
Average GS grade.....	12.5	12.5	12.5
Average GS salary.....	\$62,400	\$64,588	\$66,054

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Refugee and Entrant Assistance

<u>FY 2004 Budget</u>	<u>Page</u>
Appropriation Language and Explanation of Language Change.....	I-2
Amounts Available for Obligation.....	I-3
Summary of Change	I-4
Budget Authority by Activity	I-6
Budget Authority by Object.....	I-7
Authorizing Legislation	I-8
Appropriations History Table	I-10
Justification:	
General Statement.....	I-11
Transitional and Medical Services.....	I-14
Victims of Trafficking	I-19
Social Services.....	I-22
Victims of Torture.....	I-28
Preventive Health.....	I-30
Targeted Assistance	I-34
Unaccompanied Alien Children.....	I-38

ADMINISTRATION FOR CHILDREN AND FAMILIES
Refugee and Entrant Assistance

For making payments for refugee and entrant assistance activities authorized by title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96-422), [\$442,724,000], \$417,626,000: Provided, That funds appropriated pursuant to section 414(a) of the Immigration and Nationality Act for fiscal year [2003] 2004 shall be available for the costs of assistance provided and other activities to remain available through September 30, [2005] 2006: Provided further, That up to \$10,000,000 is available to carry out the Trafficking Victims Protection Act of 2000.

For carrying out section 5 of the Torture Victims Relief Act of 1998 (Public Law 105-320), \$10,000,000. *For carrying out section 462 of the Homeland Security Act of 2002, (P.L. 107-296), \$34,000,000.*

Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2003, as proposed in the FY 2003 President's Budget

ADMINISTRATION FOR CHILDREN AND FAMILIES

Refugee and Entrant Assistance

Amounts Available for Obligation

	<u>2002 Actual</u>	<u>2003 President's Budget</u>	<u>2004 Estimate</u>
Appropriation, Annual	\$460,203,000	\$485,724,000	\$461,626,000
Enacted Rescission	-48,000	0	0
Subtotal Adjusted Appropriation	493,155,000	485,724,000 ¹	461,626,000
Unobligated balance, start of year	41,312,000	23,796,000	10,479,000 ²
Unobligated balance, end of year	-23,796,000	-10,479,000 ²	0
Total, obligations	\$510,671,000	\$499,041,000	\$472,105,000

¹ The funds appropriated pursuant to section 414(a) of the Immigration and Nationality Act for fiscal year 2002 shall be available for the costs of assistance provided and other activities to remain available through September 2004.

² This represents an estimate of the FY 2003 unobligated balance, end of year.

Refugee and Entrant Assistance

SUMMARY OF CHANGES

FY 2003 President's Budget Request.....	\$485,724,000
Total estimated budget authority.....	485,724,000
(Obligations)	
FY 2004 Estimate.....	\$461,626,000
(Obligations)	
Net change.....	<u>-\$24,098,000</u>
(Obligations)	

	<u>2003 President's</u>		<u>Change from Base</u>	
	<u>Budget</u>	<u>Base</u>	<u>Budget</u>	<u>Base</u>
	<u>(FTE)</u>	<u>Authority</u>	<u>(FTE)</u>	<u>Authority</u>
Increases:				
A. <u>Built-in:</u>				
Care and placement of unaccompanied alien children.....		\$33,000,000		+\$1,000,000
B. <u>Program:</u>				
1. Grants for social adjustment and employment services to refugee arrivals/eligibles, including victims of trafficking		\$151,200,000		+\$2,000,000
Decreases:				
A. <u>Built-in:</u>				
None				
B. <u>Program:</u>				
1. Grants for transitional and medical assistance to refugee arrivals/eligibles, including victims of trafficking.....		\$227,291,000		-\$27,000,000

2. Reduction in level of information technology support.....	\$227,291,000	-\$98,000
Total decreases		-\$27,098,000
Net Change.....		-\$24,098,000

Refugee and Entrant Assistance

Budget Authority by Activity

	<u>2002</u> <u>Actual</u>	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>
Transitional and Medical Services.....	\$227,243,000	\$227,291,000	\$200,193,000
Victims of Trafficking..	10,000,000	10,000,000	10,000,000
Social Services.....	158,600,000	151,121,000	153,121,000
Victims of Torture.....	10,000,000	10,000,000	10,000,000
Preventive Health.....	4,835,000	4,835,000	4,835,000
Targeted Assistance.....	49,477,000	49,477,000	49,477,000
Unaccompanied Alien Children.....	33,000,000	33,000,000	34,000,000
Subtotal, Budget Authority.....	\$493,155,000	\$485,724,000	\$461,626,000
Unobligated balances, Start of year.....	41,312,000	23,796,000	10,479,000
Unobligated balances End of year.....	-23,796,000	-10,479,000	0
Total Budget Authority..	\$510,671,000	\$499,041,000	\$472,105,000

Refugee and Entrant Assistance

Budget Authority by Object

	2003 President's <u>Budget</u>	2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Salaries and benefits (11.1 & 12.1).....	\$1,965,000	\$2,026,000	+\$61,000
Travel and transportation of persons (21.0)	135,000	140,000	+5,000
Advisory and assistance services (25.1).....	1,205,000	1,200,000	-5,000
Other services (25.2).....	2,355,000	2,360,000	+5,000
Purchase of goods and services from government accounts (25.3)	1,750,000	1,657,000	-93,000
Grants, subsidies, and Contributions (41.0)	491,631,000	464,722,000	-26,909,000
Total, budget authority by object	\$499,041,000	\$472,105,000	-\$26,936,000

Refugee and Entrant Assistance

Authorizing Legislation

	<u>2003 Amount Authorized</u>	<u>2003 President's Budget</u>	<u>2004 Amount Authorized</u>	<u>2004 Budget Request</u>
Section 414(a) of the Immigration and Nationality Act, as amended, Section 501 of the Refugee Education Assistance Act of 1980 (reauthorization legislation pending Congressional action):				
1. Transitional and Medical Services.....	Such sums	\$227,291,000	\$200,193,000	\$200,193,000
2. Social Services.....	Such sums	151,121,000	153,121,000	153,121,000
3. Preventive Health ...	Such sums	4,835,000	4,835,000	4,835,000
4. Targeted Assistance	Such sums	49,477,000	49,477,000	49,477,000
Section 13(b) of the Victims of Trafficking and Violence Prevention Act of 2000 (reauthorization legislation pending Congressional action):				
Victims of Trafficking ..	10,000,000	10,000,000	10,000,000	10,000,000
Section 5 of the Victims of Torture Relief Act of 1998 (reauthorization requested):				
Victims of Torture	10,000,000	10,000,000	10,000,000	10,000,000

	2003 Amount <u>Authorized</u>	2003 President's <u>Budget</u>	2004 Amount <u>Authorized</u>	2004 Budget <u>Request</u>
Section 462 (a) of the Homeland Security Act of 2002:				
Unaccompanied Alien Children.....	Such sums	33,000,000	Such sums	34,000,000
Total, appropriation		\$485,724,000		\$461,626,000
Total appropriations against definite authorizations	\$20,000,000	\$20,000,000	\$20,000,000	\$20,000,000

APPROPRIATIONS HISTORY TABLE
Refugee and Entrant Assistance

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1995	413,786,000	405,779,000	405,799,000	405,772,000
1996	414,199,000	416,781,000	397,172,000	407,166,000
1997	381,526,000	412,076,000	385,609,000	426,612,460
1998	395,732,000	418,400,000	395,632,000	423,314,319
1999	415,000,000	415,165,000	415,000,000	435,264,000
2000 Rescission	442,676,000	423,500,000	430,500,000	426,505,000 332,000
2001 Rescission	432,569,000	433,109,000	425,586,000	433,109,000 6,000
2002 Rescission	445,224,000	460,224,000	445,224,000	460,203,000 48,000
2003	485,724,000			
2004	461,626,000			

Refugee and Entrant Assistance

Justification

	2002 Actual	2003 President's Budget	2004 Estimate	Increase or Decrease
Transitional and Medical Services	\$227,243,000	\$227,291,000	\$200,193,000	-\$27,098,000
Victims of Trafficking	10,000,000	10,000,000	10,000,000	0
Social Services	158,600,000	151,121,000	153,121,000	-2,000,000
Victims of Torture	10,000,000	10,000,000	10,000,000	0
Preventive Health	4,835,000	4,835,000	4,835,000	0
Targeted Assistance	49,477,000	49,477,000	49,477,000	0
Unaccompanied Alien Children	33,000,000	33,000,000	34,000,000	+1,000,000
Total, BA	\$493,155,000	\$485,724,000	\$461,626,000	-\$24,098,000

General Statement

The Refugee and Entrant Assistance program is designed to help refugees, asylees, Cuban and Haitian entrants, and trafficking victims to become employed and self-sufficient as quickly as possible. As a result of the Homeland Security Act of 2002, the program is now also responsible for coordinating and implementing the care and placement of unaccompanied alien children who are in federal custody by reason of immigration status. These duties are consistent with the Administration for Children and Families' strategic goals of increasing independence and productivity of families, increasing employment and promoting the social well-being of children. The President's appropriation request of \$461,626,000, represents the amount needed to maintain current assistance levels, and to provide additional support for victims of torture and unaccompanied alien children in federal custody.

Refugee and Entrant Assistance funds support seven programs:

- Transitional and Medical Services -- This program provides cash and medical assistance to financially needy refugees, asylees, trafficking victims and entrants who are not categorically

eligible for TANF, Medicaid, or SSI, and provides foster care services to unaccompanied minors. States are reimbursed for costs incurred to administer refugee program activities. Programs are monitored and data are collected and evaluated. Wilson/Fish projects provide alternative approaches to the State-administered programs. The Voluntary Agency Program (Matching Grant Program) provides one dollar in matching funds for every two dollars of Federal funds.

- Trafficking -- First funded in FY2001 under the Victims of Trafficking and Violence Prevention Act of 2000, this program extends eligibility for benefits and services to trafficking victims to the same extent as refugees.
- Social Services -- The Social Services activity assists refugees in the areas of social adjustment, employment services, and attainment of self-sufficiency as rapidly as possible. Services include English language training, employment-related services, and a variety of special projects and activities.
- Victims of Torture -- First funded in FY 2000 under the Torture Victims Relief Act of 1998, this program provides medical and psychological treatment, social and legal services, and rehabilitation for victims of torture.
- Preventive Health -- This program provides medical screening, outreach, orientation and access to health care for refugees to preserve the public health and ensure that health problems are not a barrier to achieving self-sufficiency.
- Targeted Assistance -- Grants are made to States to provide services to counties or other localities with large refugee populations, high refugee concentrations, and high use of public assistance.
- Unaccompanied Alien Children -- Transferred to ORR by the Homeland Security Act of 2002, this program involves the care and placement of approximately 5,000 unaccompanied alien children per year who are apprehended by INS agents, Border Patrol Officers, or other law enforcement agencies and placed in federal custody.

History of Refugee Ceilings and Arrivals

Year	Refugee Ceiling	Refugee Arrivals	Cuban/Haitian Arrivals	Trafficking Victims	Total ² Arrivals
1986	67,000	60,554			60,554
1987	70,000	58,885			58,885
1988	87,500	76,733			76,733
1989	116,500	106,538			106,538
1990	125,000	122,263			122,263
1991	131,000	113,734			113,734
1992	132,000	131,611			131,611
1993	120,000	119,099	4,457		123,556
1994	120,000	112,084	14,359		126,443
1995	110,000	99,532	31,782		131,314
1996	90,000	75,721	9,494		85,215
1997	78,000	76,434	7,345		83,779
1998	83,000	76,742	16,984		93,726
1999	91,000	85,019	21,079		106,098
2000	90,000	72,519	19,441		91,960
2001	80,000	68,393	15,605	200	84,198
2002	70,000	26,383	16,694	99	43,176
2003	70,000				
2004	80,000				

Since 1995, Congress has provided bill language permitting the reappropriation of carryover balances to support current year activities. It is estimated that the FY 2004 request of \$483,450,000, together with a carryover balance of approximately \$23.8 million, will be sufficient to effectively administer this program, to continue to provide eight months of cash and medical assistance to eligible refugees, and to provide a variety of social and educational services, including services to victims of torture, victims of trafficking and unaccompanied alien children in Federal custody.

The President's appropriation request of \$461,626,000 in new budget authority represents current law requirements. No proposed law amounts are included.

¹ Refugee ceilings are established through Presidential Determination. Not reflected in the ceiling are (1) Cuban/Haitian entrants, most of whom are paroled into the U.S. under a bilateral agreement reached with Cuba in FY 1995, (2) asylees, who are eligible refugee benefits since May 2000, and (3) victims of trafficking who have been eligible for refugee benefits since July 2001.

² Total arrivals do not include asylees, who beginning in FY 2000 became eligible for refugee benefits. In FY 2000 37,942 individuals were granted asylum in the United States.

TRANSITIONAL AND MEDICAL SERVICES

Authorizing Legislation – Legislation to reauthorize Section 414 of the Immigration and Nationality Act and Section 501 of the Refugee Education Assistance Act of 1980 is pending Congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase Or Decrease
\$227,243,000	\$227,291,000	\$200,193,000	-\$27,098,000

2004 Authorization....Such sums (as requested in pending legislation.)

Purpose and Method of Operation

This program supports the goal of the Administration for Children and Families to increase economic independence and productivity for families, and to increase employment.

Historically, assistance to unaccompanied refugee, asylee, or entrant minors has been the top priority for the cash and medical assistance program. This activity reimburses States for providing foster care to an unaccompanied minor until the child reaches the age of eighteen. If a State has established a later age for emancipation from foster care, reimbursements will be provided until that date.

Cash and medical assistance is also provided, during their first eight months in the United States, to adult refugees, asylees, entrants and certified trafficking victims who are not categorically eligible for TANF, Medicaid and SSL. State refugee program offices operate these activities. They are reimbursed for costs incurred to administer the refugee programs and to provide assistance and services to unaccompanied refugee minors, asylees, entrants or trafficking victims under the age of eighteen.

Under the Voluntary Agency Program (Matching Grant Program), participating national voluntary refugee resettlement agencies, many of which are faith-based organizations, provide a match (in cash or in-kind services) of one dollar for every two dollars of federal contribution. The participating agencies provide services such as case management, job development, job placement and follow-up, and interim cash assistance to help refugees become employed and self-sufficient within their first four months in the U.S. Participating refugees may not access public cash assistance.

Section 412(e)(7)(A) of title IV of the Immigration and Nationality Act authorizes the use of funds to develop and implement alternative projects for refugees that encourage refugee self-sufficiency. Wilson/Fish projects currently are funded in nine States and provide interim financial and medical assistance for newly arrived refugees to increase their prospects for early employment and self-sufficiency and to reduce welfare dependency.

Section 412(a)(7) of title IV of the Immigration and Nationality Act authorizes the use of funds for monitoring and evaluation activities.

Funding for Transitional and Medical Services during the last past five years has been as follows:

1999.....	\$220,535,000
2000.....	\$220,653,000
2001.....	\$220,170,000
2002.....	\$227,243,000
2003.....	\$200,193,000

Rationale for the Budget Request

The FY 2004 request for Transitional and Medical Services is \$200,193,000, a decrease of \$27.1 million from the FY 2003 President's Budget. At this level of funding, we will be able to continue the eight months of cash and medical assistance to eligible refugees, entrants, asylees, and trafficking victims, as well as foster care services for refugee, entrant, asylee, and trafficking minors until emancipation. This reduced funding level reflects the decreased number of refugees arriving in the U.S. since September 2001 due to the implementation of additional security clearance procedures overseas. Since that date, refugee arrivals have decreased by over 60 percent. This line item also funds the Voluntary Agency Program (Matching Grant Program), an alternative to welfare for newly arrived refugees within their first four months in the U.S. Legislation to reauthorize the program, as requested in the FY 2003 President's Budget, is pending Congressional action.

RESOURCE AND PROGRAM DATA
TRANSITIONAL AND MEDICAL SERVICES

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$154,074,000	\$155,764,000	\$128,764,000
Discretionary	68,861,000	68,000,000	68,000,000
Research/Evaluation	2,708,000	2,602,000	2,602,000
Demonstration/Development			
Training/Technical Assistance			
Program Support ¹	911,000	925,000	827,000
Total, Resources	\$226,554,000	\$227,291,000	\$200,193,000
Program Data:			
Number of Grants	66	68	68
New Starts:			
#		2	9
\$		\$1,000,000	\$68,000,000
Continuations:			
#	66	66	59
\$	\$222,935,000	\$222,764,000	\$128,764,000
Contracts:			
#	6	6	6
\$	\$3,619,000	\$3,527,000	\$3,429,000
Interagency Agreements:			
#			
\$			

¹ Includes funding for information technology support, data collection and monitoring support, and conference contract costs.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Refugee and Entrant Assistance –TMS (CFDA # 93.566)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$0	\$0	\$0	\$0
Alaska	0	0	0	0
Arizona	5,209,000	5,282,000	4,369,000	-913,000
Arkansas	30,000	30,000	25,000	-5,000
California	26,584,000	26,958,000	22,300,000	-4,658,000
Colorado	2,017,000	2,045,000	1,692,000	-353,000
Connecticut	1,250,000	1,268,000	1,049,000	-219,000
Delaware	20,000	20,000	17,000	-3,000
District of Columbia	1,210,000	1,227,000	1,015,000	-212,000
Florida	29,600,000	30,016,000	24,829,000	-5,187,000
Georgia	4,629,000	4,694,000	3,883,000	-811,000
Hawaii	83,000	84,000	69,000	-15,000
Idaho	592,000	600,000	496,000	-104,000
Illinois	5,227,000	5,301,000	4,385,000	-916,000
Indiana	583,000	591,000	489,000	-102,000
Iowa	524,000	531,000	440,000	-91,000
Kansas	231,000	234,000	194,000	-40,000
Kentucky	0	0	0	0
Louisiana	222,000	225,000	186,000	-39,000
Maine	438,000	444,000	367,000	-77,000
Maryland	3,890,000	3,945,000	3,263,000	-682,000
Massachusetts	6,400,000	6,490,000	5,369,000	-1,121,000
Michigan	6,933,000	7,031,000	5,816,000	-1,215,000
Minnesota	4,920,000	4,989,000	4,127,000	-862,000
Mississippi	1,112,000	1,128,000	933,000	-195,000
Missouri	790,000	801,000	663,000	-138,000
Montana	70,000	71,000	59,000	-12,000
Nebraska	527,000	534,000	442,000	-92,000
Nevada	0	0	0	0
New Hampshire	548,000	556,000	460,000	-96,000
New Jersey	1,658,000	1,681,000	1,390,000	-291,000
New Mexico	1,012,000	1,026,000	849,000	-177,000
New York	8,800,000	8,924,000	7,380,000	-1,544,000
North Carolina	1,621,000	1,644,000	1,360,000	-284,000
North Dakota	1,037,000	1,052,000	870,000	-182,000

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	1,716,000	1,740,000	1,440,000	-300,000
Oklahoma	600,000	608,000	503,000	-105,000
Oregon	2,291,000	2,323,000	1,922,000	-401,000
Pennsylvania	6,060,000	6,145,000	5,083,000	-1,062,000
Rhode Island	157,000	159,000	132,000	-27,000
South Carolina	111,000	113,000	93,000	-20,000
South Dakota	332,000	337,000	278,000	-59,000
Tennessee	803,000	814,000	674,000	-140,000
Texas	3,471,000	3,520,000	2,912,000	-608,000
Utah	1,031,000	1,046,000	865,000	-181,000
Vermont	424,000	430,000	356,000	-76,000
Virginia	4,592,000	4,657,000	3,852,000	-805,000
Washington	13,882,000	14,077,000	11,644,000	-2,433,000
West Virginia	5,000	5,000	4,000	-1,000
Wisconsin	831,000	843,000	697,000	-146,000
Wyoming	0	0	0	0
Subtotal	154,074,000	156,241,000	129,241,000	-27,00,000
Discretionary Fund	68,861,000	68,000,000	68,000,000	0
Other	3,619,000	3,050,000	2,952,000	-98,000
Subtotal adjustments	72,480,000	71,050,000	70,952,000	-98,000
TOTAL RESOURCES	\$226,554,000	\$227,291,000	\$200,193,000	-\$27,098,000

VICTIMS OF TRAFFICKING

Authorizing Legislation -- Legislation to reauthorize the Victims of Trafficking and Violence Protection Act of 2000, P.L. 106-386, section 107(b)(1) is pending Congressional action.

2002 Enacted	2003 Appropriation	2004 Estimate	Increase Or Decrease
\$10,000,000	\$10,000,000	\$10,000,000	\$0

2004 Authorization....Such sums (as included in the pending FY 2003 straight-line reauthorization of the program).

Purpose and Method of Operation

This program supports the Administration for Children and Families' goal to provide Office of Refugee Resettlement-funded services and benefits to victims of trafficking. This program activity is funded out of the Refugee and Entrant appropriation.

In October 2000, the Victims of Trafficking and Violence Protection Act of 2000 was enacted. The goals of the law are to prevent human trafficking overseas, increase prosecution of human traffickers here in the United States, protect the victims and provide Federal and State assistance to certain victims. Trafficking victims are defined as people who are sexually exploited or compelled to provide labor through physical force, fraud, or coercion. Estimates indicate that there may be thousands of victims in the United States.

This program extends eligibility for benefits and services to trafficking victims to the same extent as refugees. The law specifically requires HHS, in consultation with the Attorney General, to certify adult trafficking victims as a pre-condition for their eligibility. Once certified, adult trafficking victims will be eligible to apply for benefits and services under any Federal or State funded programs, to the same extent as refugees. Adult trafficking victims may be eligible for refugee cash and medical assistance and social services. Victims under 18 years of age do not need such certification in order to be eligible for benefits and services under the refugee unaccompanied minor program, but rather receive eligibility letters.

Funding for Victims of Trafficking in previous years has been as follows:

2001.....	\$ 5,000,000
2002.....	\$ 10,000,000
2003.....	\$ 10,000,000

Rationale for the Budget Request

The FY 2004 request for Victims of Trafficking is \$10,000,000, consistent with the FY 2003 President's Budget request to reauthorize the program. These funds will ensure continued administration of a national network for identification, tracking and certification of trafficking victims.

Resource and Program Data
Victims of Trafficking

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary	\$3,369,000	\$8,670,000	\$8,670,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support ¹	1,345,000	1,330,000	1,330,000
Total, Resources	\$4,714,000	\$10,000,000	\$10,000,000
<u>Program Data:</u>			
Number of Grants	14	24	24
New Starts:			
#	14	10	
\$	\$3,369,000	\$5,301,000	
Continuations:			
#		14	24
\$		\$3,369,000	\$8,670,000
Contracts:			
#	3	3	3
\$	\$1,088,000	\$1,005,000	\$1,000,000
Interagency Agreements:			
#			
\$			

¹ Includes funding for staff support and outreach and education campaign contract.

SOCIAL SERVICES

Authorizing Legislation – Legislation to reauthorize Section 414 of the Immigration and Nationality Act and Section 501 of the Refugee Education Assistance Act of 1980 is pending Congressional action.

2002 Enacted	2003 Appropriation	2004 Estimate	Increase Or Decrease
\$158,600,000	\$151,121,000	\$153,121,000	+\$2,000,000

2004 Authorization....Such sums (as requested in pending legislation).

Purpose and Method of Operation

This activity supports the Administration for Children and Families' goal to increase economic independence and productivity for families, and to increase employment. In FY 2004, approximately \$72 million of the funds available for this activity will be allocated by formula to States based on the most recent three-year arrival population. Approximately \$13 million will support social services discretionary programs. In keeping with Congressional intent, approximately \$19 million will be allocated to communities affected by recent arrivals of Cuban and Haitian refugees and entrants; \$26 million will assist communities with large concentrations of refugees whose cultural differences make assimilation difficult; and \$14 million will assist those adversely affected by welfare reform. In addition, in FY 2004, approximately \$7.5 million will be available for continuation grants to increase educational support to schools with a significant proportion of refugee children. Funding for Social Services during the last five years has been as follows:

1999.....	\$205,694,000
2000.....	\$143,621,000
2001.....	\$143,621,000
2002.....	\$158,600,000
2003.....	\$151,121,000

Rationale for the Budget Request

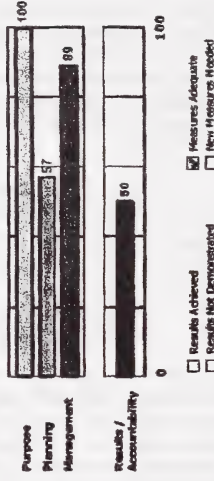
The FY 2004 request for Social Services is \$153,121,000, \$2 million more than the FY 2003 President's Budget. The funds requested will support State-administered programs emphasizing employment-related activities. Social Services assist refugees in obtaining employment and attaining social adjustment as quickly as possible. Priority is given to English language training, case management, employment preparation, and job placement and retention services. The additional \$2 million will be for independent and quality evaluations of the social services program. This activity was prompted by a review of refugee employment programs in the Administration's Program Assessment Rating Tool (PART). The assessment indicates that while this program's

purpose and mission are clear, it is weak in strategic planning namely because the program fails to conduct independent evaluations. These evaluations are intended to assess the effectiveness of the social services program. A summary of the PART assessment follows on the next page.

In FY 2004, Social Services funds, together with Targeted Assistance funds, will increase the percentage of refugees who enter employment by at least five percent annually from the FY 2003 actual performance. These funds will also increase the percent of cases in which a welfare cash termination occurs due to earnings by at least five percent annually from the FY 2003 actual performance level. Legislation to reauthorize the program, as requested in the FY 2003 President's Budget, is pending Congressional action.

Program: Refugee and Entrant Assistance

Agency: Department of Health and Human Services
Bureau: Administration for Children and Families



Key Performance Measures	Year		Target	Actual
	2012	2011		
Long-term Measure: Long-term employment of refugees relative to the number of refugees receiving employment services (New measure)			85%	
Annual Measure: Number of refugees entering employment through the Administration for Children and Families (ACF) funded refugee employment services	2001	56,885		45,893
	2002	48,188		
	2003	Increase by 3%		
	2004	Increase by 3%		
Annual Measure: Number of entered employment with health benefits included as a subset of full-time job placements	2001	30,613		27,270
	2002	28,702		
	2003	Increase by 3%		
	2004	Increase by 3%		

Rating: Adequate

Program Type: Block/Formula Grants

Program Summary:

The Office of Refugee and Resettlement's Entrant Assistance Social Services programs (ORR) helps recently arrived refugees get a job as soon as possible.

The assessment indicates:

1. The program purpose and mission are clear. Social services for refugee populations are provided by ORR's Office of Refugee Resettlement. About 63% of the approximately 70,000 refugees who arrive annually speak no English and require intensive English language and job training.
2. ORR is weak in strategic planning because it falls to: (a) conduct independent evaluations, (b) align program budget with goals and (c) utilize a system to identify strategic planning deficiencies.
3. ORR's management is generally strong. For instance, the program collects performance data from States.
4. Financial management is good although this program is subject to numerous congressional earmarks, which complicates financial management processes.
5. The results section score is largely due to the fact that the program recently established long-term outcome goals for which data are not yet available.
6. The program tracks and revises unit costs as a measure of effectiveness, but does not set performance targets to reduce unit costs as part of their annual goals.

In response to these findings:

1. The budget includes funds (\$2 million) for ORR to conduct independent and quality reviews.
2. ORR will establish targets for unit costs as an annual measure of cost-effectiveness.
3. The agency will continue its ongoing efforts to improve strategic planning to ensure that goals are measurable and linked to the budget, and systems are in place to identify program deficiencies.

Program Funding Level (in millions of dollars)

	2002 Actual	2003 Estimate	2004 Estimate
	208	201	201

RESOURCE AND PROGRAM DATA
SOCIAL SERVICES

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$71,910,000	\$71,910,000	\$71,910,000
Discretionary	77,851,000	76,711,000	76,711,000
Research/Evaluation			2,000,000
Demonstration			
Training/Technical Assistance	2,459,000	2,500,000	2,500,000
Program Support ¹	150,000		
Total, Resources	\$152,370,000	\$151,121,000	\$153,121,000
Program Data:			
Number of Grants	234	236	352
New Starts: ²			
#	69	127	125
\$	\$125,217,000	\$113,910,000	\$109,910,000
Continuations:			
#	165	109	227
\$	\$27,003,000	\$37,211,000	\$41,211,000
Contracts:			
#			1
\$			\$2,000,000
Interagency Agreements:			
#	1		
\$	\$150,000		

¹ Includes funding for interagency agreement with the Office of International and Refugee Health.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Refugee and Entrant Assistance--Social Services (CFDA # 93.566)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$102,000	\$102,000	\$102,000	\$0
Alaska	75,000	75,000	75,000	0
Arizona	1,824,000	1,824,000	1,824,000	0
Arkansas	75,000	75,000	75,000	0
California	7,451,000	7,451,000	7,451,000	0
Colorado	793,000	793,000	793,000	0
Connecticut	869,000	869,000	869,000	0
Delaware	75,000	75,000	75,000	0
District of Columbia	165,000	165,000	165,000	0
Florida	15,984,000	15,984,000	15,984,000	0
Georgia	2,575,000	2,575,000	2,575,000	0
Hawaii	75,000	75,000	75,000	0
Idaho	668,000	668,000	668,000	0
Illinois	2,296,000	2,296,000	2,296,000	0
Indiana	407,000	407,000	407,000	0
Iowa	1,124,000	1,124,000	1,124,000	0
Kansas	148,000	148,000	148,000	0
Kentucky	1,083,000	1,083,000	1,083,000	0
Louisiana	324,000	324,000	324,000	0
Maine	269,000	269,000	269,000	0
Maryland	1,019,000	1,019,000	1,019,000	0
Massachusetts	1,615,000	1,615,000	1,615,000	0
Michigan	2,223,000	2,223,000	2,223,000	0
Minnesota	3,288,000	3,288,000	3,288,000	0
Mississippi	75,000	75,000	75,000	0
Missouri	1,888,000	1,888,000	1,888,000	0
Montana	75,000	75,000	75,000	0
Nebraska	424,000	424,000	424,000	0
Nevada	490,000	490,000	490,000	0
New Hampshire	416,000	416,000	416,000	0
New Jersey	1,332,000	1,332,000	1,332,000	0
New Mexico	198,000	198,000	198,000	0
New York	5,580,000	5,580,000	5,580,000	0
North Carolina	835,000	835,000	835,000	0
North Dakota	301,000	301,000	301,000	0

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	1,544,000	1,544,000	1,544,000	0
Oklahoma	100,000	100,000	100,000	0
Oregon	1,033,000	1,033,000	1,033,000	0
Pennsylvania	1,990,000	1,990,000	1,990,000	0
Rhode Island	193,000	193,000	193,000	0
South Carolina	94,000	94,000	94,000	0
South Dakota	311,000	311,000	311,000	0
Tennessee	714,000	714,000	714,000	0
Texas	3,196,000	3,196,000	3,196,000	0
Utah	717,000	717,000	717,000	0
Vermont	213,000	213,000	213,000	0
Virginia	1,363,000	1,363,000	1,363,000	0
Washington	3,730,000	3,730,000	3,730,000	0
West Virginia	75,000	75,000	75,000	0
Wisconsin	496,000	496,000	496,000	0
Wyoming	0	0	0	0
Subtotal	71,910,000	71,910,000	71,910,000	0
Discretionary	77,851,000	76,711,000	76,711,000	0
Other	2,609,000	2,500,000	4,500,000	2,000,000
Subtotal adjustments	80,460,000	79,211,000	81,211,000	2,000,000
TOTAL RESOURCES	\$152,370,000	\$151,121,000	\$153,121,000	\$2,000,000

VICTIMS OF TORTURE

Authorizing Legislation – Straight-line reauthorization of Section 5 of the Torture Victims Relief Act of 1998 is requested.

2002 Enacted	2003 Appropriation	2004 Estimate	Increase or Decrease
\$10,000,000	\$10,000,000	\$10,000,000	\$0

2004 Authorization....\$10,000,000 (as included in the proposed straight-line reauthorization of the program).

Purpose and Method of Operation

This program supports the Administration for Children and Families' goal to provide services and rehabilitation for victims of torture. Allowable services include treatment, social and legal services, and provision of research and training to health care providers to enable them to treat the physical and psychological effects of torture. Funding for Victims of Torture during the last five years has been as follows:

1999	\$ 0
2000	\$ 7,265,000
2001	\$10,000,000
2002	\$10,000,000
2003	\$10,000,000

Rationale for the Budget Request

The FY 2004 request for reauthorizing legislation of the Victims of Torture Program at \$10,000,000 is consistent with the FY 2003 budget request. This activity will provide a comprehensive program of support for domestic centers and programs for victims of torture. The funds will be used to provide direct rehabilitation, social, and legal services to victims of torture, with special emphasis on timely and appropriate services to asylum applicants entering the United States who have been recent victims of torture.

These funds also will support training of health care professionals to enable them to recognize and treat the physical and psychological effects of torture and for identifying and sharing best practices in rehabilitation services among health care professionals through conferences and professional symposia.

Resource and Program Data
Victims of Torture

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$9,500,000	\$9,500,000	\$9,500,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	500,000	500,000	500,000
Program Support			
Total, Resources	\$10,000,000	\$10,000,000	\$10,000,000
Program Data:			
Number of Grants	29	29	30
New Starts:			
#			30
\$			\$10,000,000
Continuations:			
#	29	29	
\$	\$10,000,000	\$10,000,000	
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

PREVENTIVE HEALTH

Authorizing Legislation -- Legislation to reauthorize Section 414 of the Immigration and Nationality Act and Section 501 of the Refugee Education Assistance Act of 1980 is pending Congressional action.

2002 Enacted	2003 Appropriation	2004 Estimate	Increase Or Decrease
\$4,835,000	\$4,835,000	\$4,835,000	\$0

2004 Authorization....Such sums (as required in pending legislation).

Purpose and Method of Operation

This program supports the Administration for Children and Families' goal to enhance economic independence and productivity for families, and to increase employment. The Office of Refugee Resettlement recognizes that a refugee's medical condition may affect public health as well as prevent a refugee from achieving economic self-sufficiency. Funds for preventive health services are awarded to States through this discretionary grant program to provide health screening/assessment services to refugees.

Funding for Preventive Health during the last five years has been as follows:

1999	\$4,835,000
2000	\$4,835,000
2001	\$4,835,000
2002	\$4,835,000
2003	\$4,835,000

Rationale for the Budget Request

The FY 2004 request for Preventive Health is \$4,835,000, consistent with the FY 2003 budget request. This will ensure adequate health assessment activities for refugees. Grant funds are used for State level coordination of public health programs, outreach and interpreter services, health screening services, and referral for medical, dental, and rehabilitative services. Legislation to reauthorize the program, as requested in the FY 2003 President's Budget, is pending Congressional action.

Resource and Program Data
Preventive Health

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary	\$4,738,000	\$4,635,000	\$4,635,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support ¹	97,000	200,000	200,000
Total, Resources	\$4,835,000	\$4,835,000	\$4,835,000
Program Data:			
Number of Grants	22	22	22
New Starts:			
#		22	
\$		\$4,635,000	
Continuations:			
#	22		22
\$	\$4,738,000		\$4,635,000
Contracts:			
#			
\$			
Interagency Agreements:			
#	1	1	1
\$	\$97,000	\$200,000	\$200,000

¹ Interagency agreement with Office of International and Refugee Health.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Refugee and Entrant Assistance—Preventive Health (CFDA # 93.566)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$58,000	\$57,000	\$57,000	\$0
Alaska	0	0	0	0
Arizona	175,000	171,000	171,000	0
Arkansas	0	0	0	0
California	820,000	802,000	802,000	0
Colorado	150,000	147,000	147,000	0
Connecticut	90,000	88,000	88,000	0
Delaware	0	0	0	0
District of Columbia	100,000	97,000	97,000	0
Florida	1,000,000	978,000	978,000	0
Georgia	193,000	189,000	189,000	0
Hawaii	76,000	75,000	75,000	0
Idaho	70,000	68,000	68,000	0
Illinois	231,000	226,000	226,000	0
Indiana	75,000	73,000	73,000	0
Iowa	0	0	0	0
Kansas	36,000	35,000	35,000	0
Kentucky	0	0	0	0
Louisiana	93,000	91,000	91,000	0
Maine	0	0	0	0
Maryland	222,000	217,000	217,000	0
Massachusetts	449,000	440,000	440,000	0
Michigan	189,000	185,000	185,000	0
Minnesota	300,000	294,000	294,000	0
Mississippi	80,000	78,000	78,000	0
Missouri	124,000	122,000	122,000	0
Montana	0	0	0	0
Nebraska	0	0	0	0
Nevada	0	0	0	0
New Hampshire	117,000	114,000	114,000	0
New Jersey	0	0	0	0
New Mexico	0	0	0	0
New York	0	0	0	0
North Carolina	0	0	0	0
North Dakota	90,000	88,000	88,000	0

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	0	0	0	0
Oklahoma	0	0	0	0
Oregon	0	0	0	0
Pennsylvania	0	0	0	0
Rhode Island	0	0	0	0
South Carolina	0	0	0	0
South Dakota	0	0	0	0
Tennessee	0	0	0	0
Texas	0	0	0	0
Utah	0	0	0	0
Vermont	0	0	0	0
Virginia	0	0	0	0
Washington	0	0	0	0
West Virginia	0	0	0	0
Wisconsin	0	0	0	0
Wyoming	0	0	0	0
Subtotal	4,738,000	4,635,000	4,635,000	0
Discretionary Fund	97,000	200,000	200,000	0
Subtotal adjustments	97,000	200,000	200,000	0
TOTAL RESOURCES	\$4,835,000	\$4,835,000	\$4,835,000	\$0

TARGETED ASSISTANCE

Authorizing Legislation -- Legislation to reauthorize Section 414 of the Immigration and Nationality Act and Section 501 of the Refugee Education Assistance Act of 1980 is pending Congressional action.

2002 Enacted	2003 Appropriation	2004 Estimate	Increase or Decrease
\$49,477,000	\$49,477,000	\$49,477,000	\$0

2004 Authorization....Such sums (as requested in pending legislation).

Purpose and Method of Operation

This program supports the Administration of Children and Families' goal to provide grants to States with counties that are impacted by high concentrations of refugees and high dependency rates. States are required by statute to pass on to the designated counties at least ninety-five percent of the funds awarded. In FY 2004, the Office of Refugee Resettlement will direct targeted assistance funds to areas with large concentrations of refugee and entrant populations to supplement available services. Services provided by this program are generally designed to secure employment for refugees within one year or less.

Funding for Targeted Assistance during the last five years has been as follows

1999	\$49,477,000
2000	\$49,477,000
2001	\$49,477,000
2002	\$49,477,000
2003	\$49,477,000

Rationale for the Budget Request

The FY 2004 request for Targeted Assistance is \$49,477,000, the same as the FY 2003 President's Budget. These funds will be awarded to States to enable counties and other jurisdictions that have high concentrations of refugees to provide needed employment services to help increase the number of refugees entering employment and to terminate cash assistance cases due to earnings. Legislation to reauthorize the program, as requested in the FY 2003 President's Budget, is pending Congressional action.

Resource and Program Data
Targeted Assistance

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$44,529,000	\$44,529,000	\$44,529,000
Discretionary	4,948,000	4,948,000	4,948,000
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$49,477,000	\$49,477,000	\$49,477,000
Program Data:			
Number of Grants	41	41	41
New Starts:			
#	28	13	
\$	\$44,529,000	\$4,948,000	
Continuations:			
#	13	28	41
\$	\$4,948,000	\$44,529,000	\$49,477,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 DISCRETIONARY STATE/FORMULA GRANTS

PROGRAM: Refugee and Entrant Assistance--Targeted Assistance (CFDA # 93.566)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$0	\$0	\$0	\$0
Alaska	0	0	0	0
Arizona	1,410,000	1,410,000	1,410,000	0
Arkansas	0	0	0	0
California	5,704,000	5,704,000	5,704,000	0
Colorado	336,000	336,000	336,000	0
Connecticut	0	0	0	0
Delaware	0	0	0	0
District of Columbia	295,000	295,000	295,000	0
Florida	10,387,000	10,387,000	10,387,000	0
Georgia	1,661,000	1,661,000	1,661,000	0
Hawaii	0	0	0	0
Idaho	288,000	288,000	288,000	0
Illinois	1,772,000	1,772,000	1,772,000	0
Indiana	0	0	0	0
Iowa	699,000	699,000	699,000	0
Kansas	0	0	0	0
Kentucky	1,018,000	1,018,000	1,018,000	0
Louisiana	0	0	0	0
Maine	0	0	0	0
Maryland	0	0	0	0
Massachusetts	871,000	871,000	871,000	0
Michigan	1,410,000	1,410,000	1,410,000	0
Minnesota	1,298,000	1,298,000	1,298,000	0
Mississippi	0	0	0	0
Missouri	1,554,000	1,554,000	1,554,000	0
Montana	0	0	0	0
Nebraska	291,000	291,000	291,000	0
Nevada	446,000	446,000	446,000	0
New Hampshire	0	0	0	0
New Jersey	0	0	0	0
New Mexico	0	0	0	0
New York	5,176,000	5,176,000	5,176,000	0
North Carolina	304,000	304,000	304,000	0
North Dakota	265,000	265,000	265,000	0

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	383,000	383,000	383,000	0
Oklahoma	0	0	0	0
Oregon	1,519,000	1,519,000	1,519,000	0
Pennsylvania	761,000	761,000	761,000	0
Rhode Island	0	0	0	0
South Carolina	0	0	0	0
South Dakota	219,000	219,000	219,000	0
Tennessee	405,000	405,000	405,000	0
Texas	2,473,000	2,473,000	2,473,000	0
Utah	718,000	718,000	718,000	0
Vermont	0	0	0	0
Virginia	895,000	895,000	895,000	0
Washington	1,971,000	1,971,000	1,971,000	0
West Virginia	0	0	0	0
Wisconsin	0	0	0	0
Wyoming	0	0	0	0
Subtotal	44,529,000	44,529,000	44,529,000	0
Discretionary Fund	4,948,000	4,948,000	4,948,000	0
Subtotal adjustments	4,948,000	4,948,000	4,948,000	0
TOTAL RESOURCES	\$49,477,000	\$49,477,000	\$49,477,000	\$0

UNACCOMPANIED ALIEN CHILDREN

Authorizing Legislation -- Section 462 of the Homeland Security Act of 2002.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$33,000,000	\$33,000,000	\$34,000,000	+\$1,000,000

2004 Authorization....Such sums.

Purpose and Method of Operation

This program was transferred from the Immigration and Naturalization Service (INS) to the ACF Office of Refugee Resettlement, effective March 1, 2003, pursuant to section 462 of the Homeland Security Act. The program is designed to provide for the care and placement of approximately 5,000 unaccompanied alien minors each year, who are apprehended in the U.S. by INS/Homeland Security agents, Border Patrol officers or other law enforcement agencies, and taken into care pending resolution of their claims for relief under U.S. immigration law or released to an adult family member or responsible adult guardian. Resolution of their claims may result in release, granting of an immigration status (such as special immigrant juvenile or asylum), voluntary departure, or removal. At any given time, approximately 600 unaccompanied alien children (UAC) are in care. Types of care currently range from foster care to shelter care to secure detention.

Funding for the Unaccompanied Alien Children Program since its transfer to ACF has been as follows:

2003.....\$33,000,000

Rationale for the Budget Request

The FY 2004 request for the Unaccompanied Alien Children Program is \$34 million, a \$1 million increase from the FY 2003 President's Budget. This increase represents an inflationary adjustment to the funding level transferred from INS in FY 2003. The FY 2003 amount is a preliminary estimate and the actual resources to be transferred to ACF as required in the Homeland Security Act will be established through the issuance of a determination order from the Office of Management and Budget.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Temporary Assistance for Needy Families

<u>FY 2004 Budget</u>	<u>Page</u>
Amounts Available for Obligation.....	J-2
Summary of Changes.....	J-3
Budget Authority by Activity	J-4
Budget Authority by Object	J-4
Authorizing Legislation	J-5
Appropriations History Table	J-6
Justification:	
General Statement.....	J-7
TANF Program Data Sheets	J-12
State Table	J-19

ADMINISTRATION FOR CHILDREN AND FAMILIES
Temporary Assistance for Needy Families

Amounts Available for Obligation

	2002 <u>Actual</u>	2003 President's <u>Budget</u>	2004 <u>Estimate</u>
Appropriation			
Permanent.....	\$17,008,625,000	\$19,008,625,000	\$17,608,625,000
Unobligated balance			
start of year.....	600,000,000	400,000,000	2,000,000,000
Unobligated balance			
lapsing	0	0	0
Unobligated balance			
end of year.....	<u>-400,000,000</u>	<u>-2,000,000,000</u>	<u>-2,400,000,000</u>
Total obligations.....	\$17,208,625,000	\$17,408,625,000	\$17,208,625,000

Temporary Assistance for Needy Families

SUMMARY OF CHANGES

FY 2003 President's Budget Request.....	\$19,008,625,000
Total estimated budget authority	\$19,408,625,000
(Obligations)	\$17,408,625,000
 FY 2004 Estimate Budget Authority	 \$17,608,625,000
(Obligations)	\$17,208,625,000
Net change budget authority	-\$1,400,000,000
Net change (Obligations)	-\$200,000,000

	<u>FY 2003 President's Budget Base</u>	<u>Change from Base</u>
Increases:		
A. <u>Program</u>		
1. Bonus to Reward High Performance ¹	[\$300,000,000]	+\$500,000,000 ²
2. TANF Research, Demonstration and Technical Assistance activities ³	[\$100,000,000]	+\$100,000,000 ³
Decreases:		
A. <u>Program</u> :		
1. Contingency Fund	\$2,000,000,000	-\$2,000,000,000 ⁴
Net Change		-\$1,400,000,000

¹ Budget Authority originally appropriated in FY 1999; grants in FY 2003 for both High Performance Bonus and TANF Research are made from unobligated balances carried forward.

² The FY 2003 President's reauthorization proposal includes \$500,000,000 for the Employment Achievement Bonus for fiscal years 2004 through 2008. The average annual total amount of the grants for each bonus year equals \$100,000,000.

³ The FY 2003 President's reauthorization proposal includes \$100,000,000 annually beginning in FY 2003 for this program. (Unobligated balances carried forward will fund this effort in FY 2003, and in FY 2004 and beyond the reauthorization proposes to appropriate \$100,000,000 annually for this activity).

⁴ The FY 2003 Presidents reauthorization proposal includes \$2,000,000,000 for the Contingency fund, available over a five-year period.

Temporary Assistance for Needy Families

Budget Authority by Activity

	FY 2002	FY 2003	FY 2004
	<u>Actual</u>	<u>President's</u>	<u>Request</u>
		<u>Budget</u>	<u>Budget</u>
State Family Assistance Grants	\$16,488,667,000	\$16,488,667,000	\$16,488,667,000
Territories – Family Assistance grants	77,875,000	77,875,000	77,875,000
Matching Grants to Territories	15,000,000	15,000,000	15,000,000
Bonus to Reward Decrease in Illegitimacy	100,000,000	0	0
TANF Research, Demonstration and Technical Assistance Activities	0	[100,000,000]	100,000,000
Promotion of Healthy Marriage and Family Formation Grants	0	100,000,000	100,000,000
Supplemental Grants for Population Increases	319,450,000	319,450,000	319,450,000
Bonus to Reward High Performance States – Obligations non-add	[200,000,000]	[300,000,000]	500,000,000
Tribal Work Programs	7,633,000	7,633,000	7,633,000
Contingency Fund	[1,958,000,000]	2,000,000,000	[2,000,000,000]
Total, Budget Authority	\$17,008,625,000	\$19,008,625,000	\$17,608,625,000

Note: Bracketed budget authority indicates that these activities will be funded from unobligated balances carried forward from prior years.

Budget Authority by Object

	2003 President's <u>Budget</u>	2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Advisory and assistance services (25.1).....	\$20,000,000	\$20,000,000	\$0
Grants, subsidies and contributions (41.0).....	<u>\$18,988,625,000</u>	<u>\$17,588,625,000</u>	<u>-\$1,400,000,000</u>
Total, Budget Authority	\$19,008,625,000	\$17,608,625,000	-\$1,400,000,000

Temporary Assistance to Needy Families

Authorizing Legislation

	<u>2003 Amount Authorized</u>	<u>2003 President's Budget</u>	<u>2004 Amount Authorized</u>	<u>2004 Budget Request</u>
State Family Assistance Grants: Section 403(a)(1)(E) of the Social Security Act, as amended (less State penalties)	Such sums	\$16,488,667,235	Such sums	\$16,488,667,235
Territories – Family Assistance Grants: Section 403(a)(1)(E) of the Social Security Act, as amended ¹	Such sums	77,875,765	Such sums	77,875,765
Matching Grants to Territories	Such sums	15,000,000	Such sums	15,000,000
Bonus to Reward Employment Achievement (prev. High Performance)	²	[300,000,000]	500,000,000	500,000,000
TANF Research, Demonstration and Technical Assistance Activities	²	[100,000,000]	100,000,000	100,000,000
Promotion of Healthy Marriage and Family Formation Grants	²	100,000,000	100,000,000	100,000,000

¹ Section 1108 (a) of the Social Security Act provides for a limitation on payments to Puerto Rico, Guam, the Virgin Islands and American Samoa under titles I, X, XIV, XVI, parts A and E of title IV, and subsection 1108(b) (Matching grants). The limitations, which became permanent with the enactment of Public Law 96-272, were established by P.L. 104-193 and most recently amended by Section 5512 of P.L. 105-33, are as follows: \$107,255,000 for Puerto Rico, \$4,686,000 for Guam, \$3,554,000 for the Virgin Islands and \$1,000,000 for American Samoa. The limitations do not apply to the Bonus to Reward Decrease in Illegitimacy, the Bonus to Reward High Performance States, or Loans for State Welfare Programs.

² Proposed reauthorization includes \$500,000,000 beginning in FY 2004 for the Bonus to reward employment achievement (average annual amount \$100,000,000). Reauthorization also includes redirection of High Performance Bonus funding in FY 2003 for TANF Research (thereafter \$100,000,000 annually) and the elimination of the Illegitimacy Bonus in order to fund the Family Formation matching grant program for \$100,000,000 annually.

	<u>2003 Amount Authorized</u>	<u>2003 President's Budget</u>	<u>2004 Amount Authorized</u>	<u>2004 Budget Request</u>
Supplemental Grants for Population Increases: Section 403(a)(3)(E) of the Social Security Act, as amended	Such sums	319,450,226	Such sums	319,450,226
Tribal Work Programs: Section 412(a)(2)(D) of the Social Security Act, as amended	7,633,000	7,633,287	7,633,287	7,633,287
Contingency Fund: The Personal Responsibility and Work Opportunity Act of 1996, PL 104-193.	2,000,000,000	2,000,000,000	[2,000,000,000]	[2,000,000,000]
Total Appropriations		\$19,008,625,513		\$17,608,625,513

APPROPRIATIONS HISTORY TABLE
Temporary Assistance for Needy Families

<u>Year</u>	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1998				\$13,410,374,513
1999				16,672,243,513
2000				17,692,795,513
2001				16,689,175,513
2002				16,689,175,513
2003				19,008,625,513
2004				\$17,608,625,513

Temporary Assistance for Needy Families

Justification

	2003 President's Budget ¹	2004 Estimate	Increase or Decrease
State Family Assistance Grants	\$16,488,667,000	\$16,488,667,000	\$0
Territories – Family Assistance Grants	77,875,000	77,875,000	0
Matching Grants to Territories	15,000,000	15,000,000	0
Promotion of Healthy Marriage and Family Formation Grants	100,000,000	100,000,000	0
TANF Research, Demonstration and Technical Assistance Activities	[100,000,000]	100,000,000	+100,000,000
Supplemental Grants for Population Increases	319,450,000	319,450,000	0
Bonus to Reward Employment Achievement	[300,000,000]	500,000,000	+500,000,000
Tribal Work Programs	7,633,000	7,633,000	
Contingency Fund	2,000,000,000	[2,000,000,000]	-2,000,000,000
Total, BA	\$19,008,625,000	\$17,608,625,000	-\$1,400,000,000

¹ Bracketed Budget authority in FY 2003 for these activities was originally appropriated in FY 1999 for High Performance Bonuses hence the grants are made from unobligated balances. The FY 2003 President's Budget requests a five year reauthorization of \$500,000,000 for the Employment Achievement Bonus, providing \$100,000,000 per year on average for these grants.

General Statement

Title I of P. L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created the Temporary Assistance for Needy Families (TANF) program. The legislation repealed the Aid to Families with Dependent Children (AFDC) and related programs and replaced them with a single fixed block grant. Reauthorization requested for 2003 is pending congressional action.

The purpose of TANF is to increase State flexibility in operating programs designed to: (1) provide assistance to needy families so that children may be cared for in their own homes; (2) reduce dependency by promoting job preparation, work, and marriage; (3) prevent and reduce the incidence of out-of-wedlock pregnancies; and (4) encourage the formation and maintenance of two-parent families.

Building on the success of the 1996 welfare reform program, the FY 2004 budget follows the framework proposed in the President's FY 2003 budget request which includes reauthorization of PRWORA. The reauthorization maintains current program funding levels for the following activities: Family Assistance Grants to States, Tribes and Territories; Matching Grants to Territories; and Tribal Work Programs. Authority for both the Contingency Fund and Supplemental Grants for Population Increases would be reinstated. In addition, a new TANF Research, Demonstration and Technical Assistance program which will include promotion of family formation and healthy two-parent marriages activities would be established, as well as a new matching grant program focused on marriage promotion. Finally, the Bonus to Reward High Performance States would be re-focused to provide for bonuses on employment achievement.

The President's appropriation request for this account assumes passage of pending legislation included in the President's FY 2003 request.

Purpose and Method of Operation

State Family Assistance Grants: Funding under the TANF program is provided primarily through State Family Assistance Grants, which are authorized and pre-appropriated at \$16.5 billion each year. State allocations are based on historic levels of welfare spending. While States must meet certain work, participation, and maintenance of effort requirements, they have enormous flexibility with their TANF funds to design programs that promote work, responsibility and self-sufficiency, and strengthen families.

There has been a dramatic increase in employment of current and former welfare recipients. The percentage of working recipients remains high. In FY 2001, 33 percent of adult recipients were working, compared to less than 7 percent in FY 1992, and 11 percent in FY 1996. Thus, about one in three recipients was working in a typical month, the highest level ever recorded and nearly a five-fold increase since FY 1992. In FY 2001 the vast majority or 83 percent of recipients who were working were in paid employment; others were engaged in work experience and community service.

States have wide flexibility under TANF to determine their own eligibility criteria, benefit levels, and the type of services and benefits available to TANF recipients. However, States must maintain a historical level of State spending on behalf of eligible families (the maintenance of effort requirement) and must meet minimum work participation rate requirements. The proposed reauthorization also would increase flexibility for States by allowing them to spend TANF funds carried over from previous years for activities other than assistance. These activities may include spending for preventing and reducing the incidence of out-of-wedlock births, encouraging formation and maintenance of healthy, two-parent married families, or encouraging responsible fatherhood. In FY 2001, all 50 States, the District of Columbia and Puerto Rico met the overall work participation rates for all families. Additionally, of the 35 jurisdictions that have two-parent family programs subject to a work participation rate, 30 jurisdictions met the standard.

In addition, families who have received federally funded assistance under TANF for five cumulative years (or less at State option) are not eligible for federally funded assistance. States may continue to exempt up to 20 percent of their cases from this rule.

Under current law States may transfer up to a total of 30 percent of their TANF funds to either the Child Care and Development Block Grant program or the Social Services Block Grant (SSBG) program, with not more than 4.25 percent transferable to SSBG. (FY 2002 Appropriations language modified current law allowing for 10 percent transfer to SSBG). Under the proposed reauthorization, the allowable SSBG transfer would be restored to 10 percent.

Tribes are eligible to operate their own TANF programs and those that choose to do so receive their own Family Assistance Grants. The number of approved TANF plans has steadily increased since the first three tribal TANF programs started in July 1997. As of January 2003, 38 tribal TANF grantees covering 178 Tribes and Alaska Native Villages had been approved, all of which are fully operational. Thirty of the approved plans involve individual Tribes and eight are multi-tribal TANF operations.

Territories -- Family Assistance Grants: These grants provide funding to Guam, Puerto Rico and the Virgin Islands to operate their own TANF programs. Territories are subject to the same State plan, work and maintenance of effort requirements as the fifty States and the District of Columbia. A Territory's allocation is based on historic funding levels.

Matching Grants to Territories: These grants are an additional source of funding to the Territories. These Matching Grants are subject to a ceiling under Section 1108 of the Social Security Act and additional maintenance of effort requirements. Matching Grant funds may be used for the TANF program and the Foster Care, Adoption Assistance, and Independent Living programs. The Federal-matching rate for these funds is 75 percent. Use of the Matching Grant is optional.

Supplemental Grants for Population Increases: These grants were authorized to provide additional TANF funding in FYs 1998-2001 to States that experienced increases in their populations and or had low levels of welfare spending per capita. A State qualified for a grant in years after FY 1998 only if it qualified in FY 1998. Territories and Tribes were not eligible.

Seventeen States received these grants in FY 2002, after the 2002 Economic Recovery Act provided an additional year's worth of funding.

Bonus to Reward High Performance States: These grants provide bonus funds to States that meet certain performance measures reflecting how well they are achieving the goals of TANF. A total of \$1 billion was available for awards for FY 1999-2003 and the total amount awarded each year averaged \$200 million. In July 2002 twenty-six States received high performance bonuses.

Under the proposed reauthorization, these bonuses would be restructured to focus on employment achievement, and would average \$100 million per year.

Healthy Marriage Promotion Grants: The FY 2003 Budget proposes a new matching grant program targeted to effective family formation activities.

Tribal Work Programs: These grants are available to Indian Tribes and Alaska Native organizations that conducted a Job Opportunities and Basic Skills Training (JOBS) program in FY 1995. The purpose of these grants is to allow Indian Tribes and Alaska Native organizations to operate a program to make work activities available to their members. Funding is authorized and pre-appropriated at \$7,633,000 for each fiscal year.

Contingency Fund: The Contingency Fund was established to provide a funding reserve which could be used to assist States that experience unexpected economic downturns, resulting in larger than expected numbers of families receiving Temporary Assistance for Needy Families (TANF) services. In order to be eligible to receive Contingency Funds, a State must meet one of two criteria:

- 1) The State's unemployment rate for the most recent 3-month period for which data are available must exceed 6.5 percent and this rate must be at least 10 percent higher than the unemployment rate for the same 3-month period in either or both of the last two calendar years or;
- 2) The number of food stamp participants in the State must exceed by at least 10 percent the number of food stamp participants in the State in the comparable quarter of either FY 1994 or FY 1995.

The reauthorization proposal will reinstate the Contingency Fund, which would retain the above triggers, but would include a modification to the definition of maintenance of effort and simplify the annual reconciliation process.

TANF Research, Demonstration and Technical Assistance Activities: This proposed new authority would fund research, demonstration, and technical assistance activities including those that are targeted to family formation strategies and healthy marriages and reducing the incidence of out of wedlock birth. A portion of the research effort would be directed to child welfare issues in lieu of reauthorizing children's welfare research under the Children's Research and Technical Assistance account.

Rationale for the Budget Request

Welfare reform has been a major success. The number of dependent families has been cut in half. The child poverty rate has fallen substantially. The poverty rate of both black children and children in single mother families is now at the lowest point in U.S. history. The growth in out-of-wedlock births has slowed for the first time in three decades.

But even with this notable progress, much remains to be done, and States still face daunting challenges. The tasks of promoting marriage and two-parent families, of addressing the educational and growth potential of the next generation, of fully engaging fathers in the emotional and economic lives of their children, and of reducing out-of-wedlock pregnancies has hardly begun. Building on the early success of work programs, the recent emphasis on identifying and addressing barriers of work, on moving families to stable jobs, enhancing skills and wage growth is far from finished.

The past success of the first wave of welfare reform efforts provides a unique opportunity to move to the next phase of welfare reform as evidenced in the Administration's welfare reform legislation and the on going efforts of the Congress to enact welfare reform legislation.

Resource and Program Data
State Family Assistance Grant

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$16,488,667,235	\$16,488,667,235	\$16,488,667,235
Discretionary			
Research			
Demonstration			
Development			
Training/Technical Assistance			
Evaluation			
Program Support			
Other			
TOTAL PROGRAM	\$16,488,667,235	\$16,488,667,235	\$16,488,667,235
<u>Program Data:</u>			
Number of Grants ¹	89	89	89
New Starts:			
# ¹	3		
\$	18,056,438		
Continuations:			
# ¹	86	89	89
\$	16,470,610,562	16,488,667,235	16,488,667,235
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

¹ Includes Tribal plans receiving Family Assistance Grants.

Resource and Program Data
Matching Grants to Territories

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$5,632,227	\$15,000,000	\$15,000,000
Discretionary			
Research			
Demonstration			
Development			
Training/Technical Assistance			
Evaluation			
Program Support			
Other			
TOTAL PROGRAM	\$5,632,227	\$15,000,000	\$15,000,000
<u>Program Data:</u>			
Number of Grants	1	1	1
New Starts:			
#			
\$			
Continuations:			
#	1	1	1
\$	\$5,632,227	15,000,000	15,000,000
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

Resource and Program Data
Bonus to Reward Decrease in Illegitimacy

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$100,000,000		
Discretionary			
Research			
Demonstration			
Development			
Training/Technical Assistance			
Evaluation			
Program Support			
Other			
TOTAL PROGRAM	\$100,000,000		
<u>Program Data:</u>			
Number of Grants	6		
New Starts:			
#	6		
\$	\$100,000,000		
Continuations:			
#			
\$			
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

Resource and Program Data
TANF Research, Demonstration and Technical Assistance Activities

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Formula			
Discretionary			
Research		\$25,000,000	\$25,000,000
Demonstration		60,000,000	60,000,000
Development			
Training/Technical Assistance		10,000,000	10,000,000
Evaluation		5,000,000	5,000,000
Program Support			
Other			
TOTAL PROGRAM		\$100,000,000	\$100,000,000
<u>Program Data:</u>			
Number of Applicants		TBD	TBD
Number of Grants		TBD	TBD
New Starts:			
#			
\$		\$80,000,000	\$80,000,000
Continuations:			
#			
\$			
Contracts:			
#			
\$		\$20,000,000	\$20,000,000
Interagency Agreements:			
#			
\$			

Resource and Program Data
TANF Family Formation Matching Grant Program

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary		\$100,000,000	\$100,000,000
Research			
Demonstration			
Development			
Training/Technical Assistance			
Evaluation			
Program Support			
Other			
TOTAL PROGRAM		\$100,000,000	\$100,000,000
<u>Program Data:</u>			
Number of Grants		TBD	TBD
New Starts:			
#			
\$		\$100,000,000	\$100,000,000
Continuations:			
#			
\$			
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

Resource and Program Data
Bonus to Reward Employment Achievement (Obligations)

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$200,000,000	\$300,000,000	100,000,000
Discretionary			
Research			
Demonstration			
Development			
Training/Technical Assistance			
Evaluation			
Program Support			
Other			
TOTAL PROGRAM	\$200,000,000	\$300,000,000	\$100,000,000
<u>Program Data:</u>			
Number of Applicants	51	n.a. ¹	n.a.
Number of Grants	26	n.a. ¹	n.a. ¹
New Starts:			
#	26	n.a.	n.a. ¹
\$	\$200,000,000	\$300,000,000	\$100,000,000
Continuations:			
#			
\$			
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

¹ The number of applicants and grantees is not known at this time, FY's 2002 and 2003 represent obligations for High Performance Bonuses, reauthorization proposes to modify this program into the Bonus to reward employment achievement.

Resource and Program Data
Tribal Work Programs

	2002 Actual	2003 Pres. Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula	\$7,633,287	\$7,633,287	\$7,633,287
Discretionary			
Research			
Demonstration			
Development			
Training/Technical Assistance			
Evaluation			
Program Support			
Other			
TOTAL PROGRAM	\$7,633,287	\$7,633,287	\$7,633,287
<u>Program Data:</u>			
Number of Grants	78	78	78
New Starts:			
#			
\$			
Continuations:			
#	78	78	78
\$	\$7,633,287	\$7,633,287	\$7,633,287
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: Temporary Assistance for Needy Families (CFDA #93.558)

STATE/TERRITORY	FY 2002 Actual*	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Alabama	\$124,230,761	\$104,408,461	\$104,408,461	\$0
Alaska	60,264,911	60,264,911	60,264,911	0
Arizona	228,672,071	226,130,536	226,130,536	0
Arkansas	62,927,768	62,951,233	62,951,233	0
California	3,739,843,439	3,694,299,021	3,693,193,885	-1,105,136
Colorado	169,448,681	149,626,381	149,626,381	0
Connecticut	280,127,512	266,788,107	266,788,107	0
Delaware	32,290,981	32,290,981	32,290,981	0
District of Columbia	117,062,606	92,609,815	92,609,815	0
Florida	622,745,788	622,745,788	622,745,788	0
Georgia	368,024,967	368,024,967	368,024,967	0
Hawaii	103,850,027	98,904,788	98,904,788	0
Idaho	34,991,342	33,910,608	33,910,608	0
Illinois	585,056,960	585,056,960	585,056,960	0
Indiana	217,139,064	206,799,109	206,799,109	0
Iowa	138,101,207	131,524,959	131,524,959	0
Kansas	101,931,061	101,931,061	101,931,061	0
Kentucky	190,352,052	181,287,669	181,287,669	0
Louisiana	189,197,596	180,998,997	180,998,997	0
Maine	78,120,889	78,120,889	78,120,889	0
Maryland	229,098,032	229,098,032	229,098,032	0
Massachusetts	459,371,116	459,371,116	459,371,116	0
Michigan	795,175,158	775,352,858	775,352,858	0
Minnesota	270,154,377	267,161,347	267,161,347	0
Mississippi	95,803,252	95,803,252	95,803,252	0
Missouri	227,904,327	217,051,740	217,051,740	0
Montana	46,386,171	44,109,471	44,109,471	0
Nebraska	58,417,483	57,769,382	57,769,382	0
Nevada	49,909,122	47,710,284	47,710,284	0
New Hampshire	38,951,492	38,521,261	38,521,261	0
New Jersey	404,034,823	404,034,823	404,034,823	0
New Mexico	121,924,983	117,131,204	117,131,204	0
New York	2,442,930,602	2,442,930,602	2,442,930,602	0
North Carolina	338,349,547	338,349,547	338,349,547	0
North Dakota	27,719,799	26,399,809	26,399,809	0

STATE/TERRITORY	FY 2002 Actual*	FY 2003 Pres. Budget	FY 2004 Estimate	Difference +/- 2003
Ohio	727,968,260	727,968,260	727,968,260	0
Oklahoma	147,594,230	147,594,230	147,594,230	0
Oregon	166,798,629	166,798,629	166,798,629	0
Pennsylvania	719,499,305	719,499,305	719,499,305	0
Rhode Island	99,772,666	95,021,587	95,021,587	0
South Carolina	99,967,824	99,967,824	99,967,824	0
South Dakota	22,020,494	21,279,651	21,279,651	0
Tennessee	213,088,938	213,088,938	213,088,938	0
Texas	583,099,664	538,964,526	538,964,526	0
Utah	88,155,332	84,313,871	84,313,871	0
Vermont	49,720,840	47,353,181	47,353,181	0
Virginia	158,285,172	158,285,172	158,285,172	0
Washington	411,437,305	392,570,385	389,069,040	-3,501,345
West Virginia	115,685,126	110,176,310	110,176,310	0
Wisconsin	330,996,906	316,603,208	316,603,208	0
Wyoming	19,589,602	18,500,530	18,500,530	0
Subtotal	17,004,190,260	16,697,455,576	16,692,849,095	-4,606,481
Tribe Family Asst.	102,791,857	110,134,595	114,741,076	4,606,481
Guam	3,992,703	3,992,703	3,992,703	0
Puerto Rico	66,918,319	71,562,501	71,562,501	0
Virgin Islands	3,735,064	2,846,564	2,846,564	0
Subtotal	177,437,943	188,536,363	193,142,844	4,606,481
Total States/Territories	17,181,628,203	16,885,991,939	16,885,991,939	0
Tribal New Program	7,633,287	7,633,287	7,633,287	0
Employment Achieve	0	300,000,000	100,000,000	-200,000,000
TANF Research & TA	0	100,000,000	100,000,000	0
Family Formation Match	0	100,000,000	100,000,000	0
Contingency Fund	0	2,000,000,000	0	-2,000,000,000
Territories Matching	5,632,227	15,000,000	15,000,000	0
Subtotal adjustments	13,265,514	2,522,633,287	322,633,287	-2,200,000,000
TOTAL RESOURCES	\$17,194,893,717	\$19,408,625,513	\$17,208,625,513	-\$2,200,000,000

* State levels include State Family Assistance Grants, High Performance bonuses, Illegitimacy bonuses and Supplemental Grants in FY 2002. State levels for FY's 2003 and 2004 include only State Family Assistance Grants and Supplemental Grants.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Child Care Entitlement to States

<u>FY 2004 Budget</u>	<u>Page</u>
Amounts Available for Obligation.....	K-2
Summary of Changes.....	K-3
Budget Authority by Activity.....	K-4
Budget Authority by Object.....	K-4
Authorizing Legislation	K-5
Appropriations History Table.....	K-6
Justification:	
General Statement	K-7
Child Care Entitlement	K-8
State Tables.....	K-13

ADMINISTRATION FOR CHILDREN AND FAMILIES

Child Care Entitlement to States

Amounts Available for Obligation

	2002 <u>Actual</u>	2003 President's <u>Budget</u>	2004 <u>Estimate</u>
Appropriation:			
Annual	\$2,717,000,000	\$2,717,000,000	\$2,717,000,000
Re-appropriation of prior year funds.....	\$41,000,000		
Subtotal, Adjusted Appropriation.....	<u>2,758,000,000</u>	<u>2,717,000,000</u>	<u>2,717,000,000</u>
Total Obligations	\$2,758,000,000	\$2,717,000,000	\$2,717,000,000

Child Care Entitlement to States

SUMMARY OF CHANGES

FY 2003 President's Budget Request	\$2,717,000,000
Total estimated budget authority.....	\$2,717,000,000
(Obligations)	\$2,717,000,000
FY 2004 Estimate.....	\$2,717,000,000
(Obligations)	\$2,717,000,000
Net change.....	\$0
(Obligations)	\$0

Child Care Entitlement to States

Budget Authority by Activity

	<u>2002 Actual</u>	<u>2003 President's Budget</u>	<u>2004 Estimate</u>
State Mandatory Funds ...	\$1,177,524,781	\$1,177,524,781	\$1,177,524,781
Matching Child Care.....	1,519,342,719	1,478,342,719	1,478,342,719
Tribal Mandatory Funds.....	54,340,000	54,340,000	54,340,000
Training and Technical Assistance	6,792,500	6,792,500	6,792,500
Total, Budget Authority..	\$2,758,000,000	\$2,717,000,000	\$2,717,000,000

Budget Authority by Object

	<u>2003 President's Budget</u>	<u>2004 Estimate</u>	<u>Increase or Decrease</u>
Advisory and assistance services.....	\$6,792,500	\$6,792,500	\$6,792,500
Grants, subsidies, and contributions.....	2,751,207,500	2,710,207,500	2,710,207,500
Total, Budget Authority.	\$2,758,000,000	\$2,717,000,000	\$2,717,000,000

Child Care Entitlement to States

Authorizing Legislation

	2003 Amount <u>Authorized</u>	2003 President's <u>Budget*</u>	2004 Amount <u>Authorized</u>	2004 <u>Budget</u> <u>Request</u>
Section 418 of the Social Security Act	\$2,717,000,000	\$2,717,000,000	\$2,717,000,000	\$2,717,000,000

* Legislation pending Congressional action to reauthorize this program at this level.

Child Care Entitlement to States

APPROPRIATIONS HISTORY TABLE

<u>Year</u>	<u>Budget Estimate To Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1997				\$1,967,000,000
1998				\$2,070,387,000
1999				\$2,166,938,000
2000				\$2,367,000,000
2001				\$2,567,000,000
2002				\$2,717,000,000
2003	\$2,717,000,000			
2004	\$2,717,000,000			

Child Care Entitlement to States

Justification

	2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
State Mandatory Funds	\$1,177,524,781	\$1,177,524,781	\$1,177,524,781	\$0
Matching Child Care	1,519,342,719	1,478,342,719	1,478,342,719	0
Tribal Mandatory Funds	54,340,000	54,340,000	54,340,000	0
Training and Technical Assistance	6,792,500	6,792,500	6,792,500	0
Total, BA	\$2,758,000,000	\$2,717,000,000	\$2,717,000,000	\$0

General Statement

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. 104-193) combined child care entitlement programs with different target populations (AFDC Child Care, Transitional Child Care and At-Risk Child Care) with the Child Care and Development Block Grant (CCDBG) Act of 1990, as amended. Effective October 1, 1996, the discretionary and mandatory child care funding under this Act, designated the Child Care and Development Fund, allows States maximum flexibility in developing child care programs and enables States to use resources more effectively to meet local needs. The Child Care and Development Fund includes Mandatory, Matching, and Discretionary components. (See also discussion in the Child Care and Development Block Grant section.)

CHILD CARE ENTITLEMENT

Authorizing Legislation -- Legislation to reauthorize Title IV-A, section 418 of the Social Security Act, as amended is pending congressional action.

2002 Enacted	2003 President's Budget	2004 Estimate	Increase or Decrease
\$2,758,000,000	\$2,717,000,000	\$2,717,000,000	\$0

2004 Authorization.....\$2,717,000,000 (reflects reauthorization level for this program as proposed in the President's FY 2003 Budget Request)

Purpose and Method of Operation

The Child Care Entitlement Fund provides grants to States and federally recognized Tribes for the purposes of providing low-income families with financial assistance for child care, improving the quality and availability of child care, and establishing or expanding and conducting early childhood programs and before-and-after school programs.

In conjunction with the Child Care and Development Block Grant, these funds will:

- Allow each State maximum flexibility in developing child care programs and policies that best suit the needs of children and parents within each State;
- Promote parental choice to empower working parents to make their own decisions on the child care that best suits their family's needs;
- Encourage States to provide consumer education information to help parents make informed choices about child care;
- Assist States in providing child care to parents trying to achieve and maintain independence from public assistance and assist other low-income working parents to maintain quality child care services for their children; and
- Assist States in implementing the health, safety, licensing, and registration standards established in State regulations.

Mandatory Child Care -- Mandatory funds are allocated to Grantees based on historic levels of Title IV-A child care expenditures.

Matching Child Care -- Matching funds are those remaining after Mandatory funds and the two percent of the appropriation set aside for Tribes and tribal organizations are allocated. Matching

funds are available to States if three conditions are met by the end of the fiscal year in which Matching funds are awarded: (1) all Mandatory funds are obligated; (2) the State's maintenance-of-effort funds are expended; and (3) the State provides its share of Matching funds at the FMAP rate. Unobligated funds not spent by States will be available for reappropriation in the next fiscal year.

Training and Technical Assistance.— In accordance with 45 CFR paragraph 98.60(b)(1), the Secretary may withhold no more than ¼ of one percent of Child Care Development funds made available for a fiscal year for the provision of training and technical assistance to States.

Rationale for the Budget Request

The FY 2004 request of \$2,717,000,000 -- the same level as the President's FY 2003 budget request -- will provide funding to assist States in meeting the critical child care needs of families. The Child Care Entitlement Fund helps States and communities to build the supply of high quality, affordable child care. The funds will continue ACF's commitment to providing resources that allow families to become and remain self-sufficient and productive members of society. These funds also allow families to access quality child care, which promotes child development, literacy, and school readiness. All segments of society -- parents, schools, employers, health providers, faith-based institutions and other charitable agencies, States and the Federal government -- must be involved to ensure access to quality child care.

Resource and Program Data
Mandatory Child Care

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$1,177,524,781	\$1,177,524,781	\$1,177,524,781
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$1,177,524,781	\$1,177,524,781	\$1,177,524,781
Program Data:			
Number of Grants	293	290	290
New Starts:			
#			
\$			
Continuations:			
#	293	290	290
\$	\$1,177,524,781	\$1,177,524,781	\$1,177,524,781
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

Resource and Program Data
Matching Child Care

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula	\$1,519,342,719	\$1,519,342,719	\$1,519,342,719
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance			
Program Support			
Total, Resources	\$1,519,342,719	\$1,519,342,719	\$1,519,342,719
Program Data:			
Number of Grants	51	51	51
New Starts:			
#			
\$			
Continuations:			
#	51	51	51
\$	\$1,519,342,719	\$1,519,342,719	\$1,519,342,719
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

Resource and Program Data
Training and Technical Assistance

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	\$6,792,500	\$6,792,500	\$6,792,500
Program Support			
Total, Resources	\$6,792,500	\$6,792,500	\$6,792,500
Program Data:			
Number of Grants			
New Starts:			
#			
\$			
Continuations:			
#	5	5	5
\$	\$6,792,500	\$6,792,500	\$6,792,500
Contracts:			
#			
\$			
Interagency Agreements:			
#			
\$			

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: CCDF Mandatory (CFDA # 93.596)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 1/ Estimate	Difference +/- 2003
Alabama	\$16,441,707	\$16,441,707	\$16,441,707	\$0
Alaska	3,544,811	3,544,811	3,544,811	0
Arizona	19,827,025	19,827,025	19,827,025	0
Arkansas	5,300,283	5,300,283	5,300,283	0
California	85,593,217	85,593,217	85,593,217	0
Colorado	10,173,800	10,173,800	10,173,800	0
Connecticut	18,738,357	18,738,357	18,738,357	0
Delaware	5,179,330	5,179,330	5,179,330	0
District of Columbia	4,566,974	4,566,974	4,566,974	0
Florida	43,026,524	43,026,524	43,026,524	0
Georgia	36,548,223	36,548,223	36,548,223	0
Hawaii	4,971,633	4,971,633	4,971,633	0
Idaho	2,867,578	2,867,578	2,867,578	0
Illinois	56,873,824	56,873,824	56,873,824	0
Indiana	26,181,999	26,181,999	26,181,999	0
Iowa	8,507,792	8,507,792	8,507,792	0
Kansas	9,811,721	9,811,721	9,811,721	0
Kentucky	16,701,653	16,701,653	16,701,653	0
Louisiana	13,864,552	13,864,552	13,864,552	0
Maine	3,018,598	3,018,598	3,018,598	0
Maryland	23,301,407	23,301,407	23,301,407	0
Massachusetts	44,973,373	44,973,373	44,973,373	0
Michigan	32,081,922	32,081,922	32,081,922	0
Minnesota	23,367,543	23,367,543	23,367,543	0
Mississippi	6,293,116	6,293,116	6,293,116	0
Missouri	24,668,568	24,668,568	24,668,568	0
Montana	3,190,691	3,190,691	3,190,691	0
Nebraska	10,594,637	10,594,637	10,594,637	0
Nevada	2,580,422	2,580,422	2,580,422	0
New Hampshire	4,581,870	4,581,870	4,581,870	0
New Jersey	26,374,178	26,374,178	26,374,178	0
New Mexico	8,307,587	8,307,587	8,307,587	0
New York	101,983,998	101,983,998	101,983,998	0
North Carolina	69,639,228	69,639,228	69,639,228	0
North Dakota	2,506,022	2,506,022	2,506,022	0

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	70,124,656	70,124,656	70,124,656	0
Oklahoma	24,909,979	24,909,979	24,909,979	0
Oregon	19,408,790	19,408,790	19,408,790	0
Pennsylvania	55,336,804	55,336,804	55,336,804	0
Rhode Island	6,633,774	6,633,774	6,633,774	0
South Carolina	9,867,439	9,867,439	9,867,439	0
South Dakota	1,710,801	1,710,801	1,710,801	0
Tennessee	37,702,188	37,702,188	37,702,188	0
Texas	59,844,129	59,844,129	59,844,129	0
Utah	12,591,564	12,591,564	12,591,564	0
Vermont	3,944,887	3,944,887	3,944,887	0
Virginia	21,328,766	21,328,766	21,328,766	0
Washington	41,883,444	41,883,444	41,883,444	0
West Virginia	8,727,005	8,727,005	8,727,005	0
Wisconsin	24,511,351	24,511,351	24,511,351	0
Wyoming	2,815,041	2,815,041	2,815,041	0
Subtotal	1,177,524,781	1,177,524,781	1,177,524,781	0
Tribes	54,340,000	54,340,000	54,340,000	0
Subtotal	54,340,000	54,340,000	54,340,000	0
Total States/Territories	1,231,864,781	1,231,864,781	1,231,864,781	0
Technical Assistance	3,529,600	3,532,100	3,532,100	0
Subtotal	3,529,600	3,532,100	3,532,100	0
Adjustments				
TOTAL RESOURCES	\$1,235,394,381	\$1,235,396,881	\$1,235,396,881	\$0

1/ The FY 2003 allotment calculation used Census 2000 data because 2001 estimates have not been published by the Census Bureau.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES**

FY 2004 MANDATORY STATE/FORMULA GRANTS

PROGRAM: CCDF Matching (CFDA # 93.596)

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Alabama	\$22,803,334	\$22,803,334	\$22,803,334	\$0
Alaska	4,041,917	3,837,458	3,837,458	0
Arizona	29,867,432	28,414,982	28,414,982	0
Arkansas	13,918,143	13,742,062	13,742,062	0
California	202,345,010	192,511,470	192,511,470	0
Colorado	23,346,084	22,505,791	22,505,791	0
Connecticut	18,325,536	17,434,124	17,434,124	0
Delaware	4,194,685	3,996,796	3,996,796	0
District of Columbia	2,532,376	2,419,898	2,419,898	0
Florida	74,315,596	74,315,596	74,315,596	0
Georgia	46,969,407	44,737,387	44,737,387	0
Hawaii	6,391,035	6,077,437	6,077,437	0
Idaho	7,687,126	7,416,544	7,416,544	0
Illinois	70,164,324	66,742,424	66,742,424	0
Indiana	33,404,663	32,195,509	32,195,509	0
Iowa	14,671,371	14,671,371	14,671,371	0
Kansas	14,387,106	14,387,106	14,387,106	0
Kentucky	21,286,383	20,268,911	20,268,911	0
Louisiana	24,347,811	24,347,811	24,347,811	0
Maine	6,220,317	5,924,903	5,924,903	0
Maryland	29,279,003	27,869,137	27,869,137	0
Massachusetts	32,528,105	30,946,749	30,946,749	0
Michigan	53,067,749	53,067,749	53,067,749	0
Minnesota	27,153,654	25,839,064	25,839,064	0
Mississippi	15,814,248	15,614,179	15,614,179	0
Missouri	30,244,097	28,781,184	28,781,184	0
Montana	4,707,222	4,482,336	4,482,336	0
Nebraska	9,431,220	8,973,691	8,973,691	0
Nevada	11,345,185	10,804,203	10,804,203	0
New Hampshire	6,577,515	6,259,901	6,259,901	0
New Jersey	45,576,393	43,390,811	43,390,811	0
New Mexico	10,636,452	10,117,111	10,117,111	0
New York	101,291,573	96,439,140	96,439,140	0
North Carolina	42,875,908	40,785,626	40,785,626	0
North Dakota	3,295,271	3,134,709	3,134,709	0

STATE/TERRITORY	2002 Actual	2003 Pres. Budget	2004 Estimate	Difference +/- 2003
Ohio	61,571,001	58,587,556	58,587,556	0
Oklahoma	11,502,467	17,896,095	17,896,095	0
Oregon	17,957,396	17,090,771	17,090,771	0
Pennsylvania	61,888,243	58,901,198	58,901,198	0
Rhode Island	5,348,500	5,090,091	5,090,091	0
South Carolina	21,613,855	20,591,295	20,591,295	0
South Dakota	4,187,868	3,985,399	3,985,399	0
Tennessee	29,774,488	28,705,941	28,705,941	0
Texas	122,569,631	120,569,631	120,569,631	0
Utah	7,800,000	14,732,285	14,732,285	0
Vermont	3,047,752	2,904,885	2,904,885	0
Virginia	36,888,539	35,556,003	35,556,003	0
Washington	30,720,798	30,720,798	30,720,798	0
West Virginia	8,412,231	8,000,675	8,000,675	0
Wisconsin	28,648,757	27,266,251	27,266,251	0
Wyoming	2,487,341	2,487,341	2,487,341	0
Subtotal	1,519,462,118	1,478,342,719	1,478,342,719	0
Technical Assistance	3,257,900	3,260,400	3,260,400	0
Subtotal	3,257,900	3,260,400	3,260,400	0
Adjustments				
TOTAL RESOURCES	\$1,522,720,018	\$1,481,603,119	\$1,481,603,119	\$0

1/ The FY 2003 allotment calculation used Census 2000 data because 2001 estimates have not been published by the Census Bureau.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Children's Research and Technical Assistance

<u>FY 2004 Budget</u>	<u>Page</u>
Amounts Available for Obligation	L-2
Summary of Changes	L-3
Budget Authority by Activity	L-4
Budget Authority by Object	L-5
Authorizing Legislation	L-6
Appropriations History Table	L-7
Justification:	
General Statement	L-8

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Children's Research and Technical Assistance

Amounts Available for Obligation

	<u>2002</u> <u>Actual</u>	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>
Appropriation:			
Permanent.....	\$57,953,000	\$50,370,000	\$49,680,000
Enacted rescission.....	<u>-21,026,000</u>		
Subtotal, adjusted appropriation	36,927,000	50,370,000	49,680,000
Offsetting collections....	9,093,000	9,100,000	9,300,000
Subtotal, adjusted budget authority gross).....	46,020,000	59,470,000	58,980,000
Unobligated balance start of Year.....	1,459,000	1,436,000	0
Adjustment.....		-880,000	
Recovery of prior-year obligations.....	0	400,000	0
Unobligated balance, end of year.....	<u>1,436,000</u>	<u>0</u>	<u>0</u>
Total, gross obligations..	\$46,268,000	\$60,426,000	\$58,980,000

Children's Research and Technical Assistance

SUMMARY OF CHANGES

FY 2003 Estimated Appropriation.....	\$50,370,000
(Gross Obligations)	60,426,000
 FY 2004 Estimate	 49,680,000
(Obligations)	58,980,000
Net change	-690,000
(Obligations)	-1,446,000

	2003 President's <u>Budget Base</u>	<u>Change from Base</u>
Decreases:		
A. Built-in:		
1. Decrease due to lower child support collections estimated in FY 2003.....	35,370,000	-690,000
Total Decreases		-\$690,000
Net Change.....		-\$690,000

Children's Research and Technical Assistance

Budget Authority by Activity

	<u>2002</u> <u>Actual</u>	<u>2003</u> <u>President's</u> <u>Budget</u>	<u>2004</u> <u>Estimate</u>
Training and Technical Assistance	\$12,318,000	\$11,790,000	\$11,560,000
Federal Parent Locator Service	24,609,000	23,580,000	23,120,000
Child Welfare Study ¹	0	0	0
Welfare Research ¹	0	15,000,000	15,000,000
Total, Budget Authority	\$36,927,000	\$50,370,000	\$49,680,000

¹ Amounts for FY 2002 were rescinded and reappropriated in the discretionary side of the budget.

Children's Research and Technical Assistance

Budget Authority by Object

	2003 President's Budget	2004 Estimate	Increase or Decrease
Travel and transportation of persons.....	1,068,000	961,000	(107,000)
Transportation of things.....	15,000	15,000	-
Rental payments to GSA.....	674,000	674,000	-
Communications, utilities and misc.....	10,000	10,000	-
Printing and reproduction.....	107,000	107,000	-
Consulting services.....	14,506,000	14,406,000	(100,000)
Other services.....	681,000	681,000	-
Purchases of goods and services from government accounts.....	21,656,000	21,309,000	(347,000)
Supplies and materials.....	498,000	450,000	(48,000)
Equipment.....	874,000	786,000	(88,000)
Grants, subsidies and contributions.....	<u>10,281,000</u>	<u>10,281,000</u>	<u>-</u>
Total, budget authority by object class.....	50,370,000	49,680,000	(690,000)
Total, obligations ¹	60,426,000	58,980,000	(1,446,000)

¹ Obligations include fees offset from the States to repay costs associated with offset notice preparation and Federal Parent Locator Service and fees from other federal agencies to repay costs associated with the Federal Parent Locator Services. FY 2003 also includes unobligated funds.

Children's Research and Technical Assistance

Authorizing Legislation

	<u>2003 Amount Authorized</u>	<u>2003 President's Budget</u>	<u>2004 Amount Authorized</u>	<u>2004 Estimate</u>
1. Training and Technical Assistance: Section 452(j) of the Social Security Act ¹	Indefinite	\$11,790,000	Indefinite	\$11,560,000
2. Federal Parent Locator Service: Section 453(o) of the Social Security Act ²	Indefinite	23,580,000	Indefinite	23,120,000
3. Child Welfare Study: Section 429 A of the Social Security Act	0	0	0	0
4. Welfare Research: Section 413 (h) of the Social Security Act	15,000,000	15,000,000	15,000,000	15,000,000
Total Appropriation	Indefinite	\$50,370,000	Indefinite	\$49,680,000

¹ The amount authorized and appropriated is equal to 1 percent of the total amount paid to the federal government for its share of child support collections for the preceding year.

² The amount authorized and appropriated is equal to 2 percent of the total amount paid to the federal government for its share of child support collections for the preceding year.

Children's Research and Technical Assistance

APPROPRIATIONS HISTORY TABLE

<u>Fiscal Year</u>	<u>Appropriation</u>
1996	36,711,000
1997	59,548,000
Rescission	(21,000,000)
1998	76,440,000
Rescission	(21,000,000)
1999	72,816,000
Rescission	(21,000,000)
2000	59,992,000
Rescission	(21,000,000)
2001	60,627,000
Rescission	(21,000,000)
2002	57,953,000
Rescission	(21,026,000)
2003	50,370,000
2004	49,680,000

Children's Research and Technical Assistance

Justification

	2002 Actual	2003 President's Budget	2004 Estimate	Increase Or Decrease
Training and Technical Assistance [obligations]	\$12,318,000 [12,095,000]	\$11,790,000 [12,391,000]	\$11,560,000 [11,560,000]	-\$230,000 [-831,000]
Federal Parent Locator Service [obligations]	24,609,000 [34,173,000]	23,580,000 [33,035,000]	23,120,000 [32,420,000]	-460,000 [-615,000]
Welfare Research	0	15,000,000	15,000,000	0
Total, net budget authority	\$36,927,000	\$50,370,000	\$49,680,000	-690,000
[Total, obligations]	[\$46,268,000]	[\$60,426,000]	[\$58,980,000]	[-\$1,446,000]

General Statement

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) authorizes and appropriates funds for welfare research and technical support for States implementing welfare reform. In addition, the Balanced Budget Act of 1997 (P.L. 105-33) authorizes and appropriates funds for welfare research.

The following activities are supported:

- Training and Technical Assistance - to support the dissemination of information and technical assistance to the States on child support enforcement activities. It is supported by an amount equal to one percent of the amount paid to the federal government for its share of child support collections during the immediately preceding fiscal year.
- Federal Parent Locator Service - to assist States in locating non-custodial parents. It is supported by an amount equal to two percent of the amount paid to the federal government for its share of child support collections during the immediately preceding fiscal year.
- Welfare Research - to conduct research and demonstrations relating to State welfare reform efforts. The budget request includes pending FY 2003 reauthorization of these funds.

Purpose and Method of Operation

Section 345 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 includes two provisions which target funding to the Department to strengthen the federal government's capacity to influence the effectiveness of the child support enforcement program.

The first provision, earmarking an amount equivalent to one percent of the federal share of child support collections in the prior year, has a two-fold purpose: to cover the Department's costs in providing technical assistance to States (including technical assistance related to State automated systems), training of State and federal staff, staffing studies, information dissemination and related activities; and, to support research, demonstration, and special projects of regional or national significance relating to the operation of State child support programs. These activities are key to successful State outcomes in implementing welfare reform and attaining the anticipated benefits of the statute. Amounts under this provision are available until expended.

The second, pertaining to an amount equal to two percent of the federal share of child support collections in the prior year, is directed to cover the Department's costs in operating the Federal Parent Locator Service to the extent that these costs are not recovered through fees. Under welfare reform the mission and scope of the Federal Parent Locator Service was significantly expanded to add two new components--a Federal Child Support Case Registry and a National Directory of New Hires. This expansion has had a significant impact on the program's ability to collect support in interstate child support cases. Interstate cases comprise about one-third of the caseload and are among the hardest for States to work. Amounts under this provision are available on an annual basis.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 also includes funding for welfare reform research. Specifically, funding is authorized for the cost of conducting research; the cost of developing and evaluating innovative approaches for reducing welfare dependency and increasing the well-being of minor children; the federal share of any State-initiated study; the operation and evaluation of demonstrations that were in effect under section 1115 as of September 30, 1995. The FY 2003 President's budget includes reauthorization of PRWORA and also reflects funding for Child Welfare research activities within the TANF Research, Demonstration and Technical Assistance Activities budget request.

Resource and Program Data
CSE Training and Technical Assistance (Obligations)

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development			
Training/Technical Assistance	\$6,538,000	\$6,356,000	\$5,385,000
Program Support ¹	5,557,000	6,035,000	6,175,000
Total, Resources	\$12,095,000	\$12,391,000	\$11,560,000
<u>Program Data:</u>			
Number of Grants		8	8
New Starts:			
#		8	8
\$		\$1,500,000	\$1,500,000
Continuations:			
#			
\$			
Contracts:			
#	10	10	10
\$	\$2,566,000	\$2,589,000	\$2,450,000
Interagency Agreements:			
#	8	8	8
\$	\$1,316,000	\$1,316,000	\$1,000,000

¹ Includes funding for information technology, salaries/benefits and associated overhead costs.

Resource and Program Data
CSE Federal Parent Locator Services (Obligations)

	2002 Actual	2003 President's Budget	2004 Estimate
Resource Data:			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation			
Demonstration/Development	\$6,270,000	\$7,084,000	\$7,000,000
Training/Technical Assistance			
Program Support ¹	27,903,000	25,951,000	25,420,000
Total, Resources	\$34,173,000	\$33,035,000	\$32,420,000
Program Data:			
Number of Grants		4	4
New Starts:			
#		4	4
\$		\$814,000	\$800,000
Continuations:			
#			
\$			
Contracts:			
#	4	4	4
\$	\$23,129,000	\$22,050,000	\$21,000,000
Interagency Agreements:			
#	6	5	5
\$	\$4,755,000	\$4,534,000	\$4,500,000

¹ Includes funding for information technology, salaries/benefits and associated overhead, program development, modernization, enhancements, and maintenance costs.

Resource and Program Data
Welfare Research

	2002 Actual	2003 President's Budget	2004 Estimate
<u>Resource Data:</u>			
Service Grants:			
Formula			
Discretionary			
Research/Evaluation		\$11,000,000	\$11,000,000
Demonstration/Development		3,000,000	3,000,000
Training/Technical Assistance			
Program Support ¹		1,000,000	1,000,000
Total, Resources		\$15,000,000	\$15,000,000
<u>Program Data:</u>			
Number of Grants		40	40
New Starts:			
#		10	10
\$		\$2,000,000	\$2,000,000
Continuations:			
#		20	20
\$		\$6,000,000	\$6,000,000
Contracts:			
#		8	8
\$		\$4,000,000	\$4,000,000
Interagency Agreements:			
#		5	5
\$		\$2,000,000	\$2,000,000

¹ Includes funding for information technology and administrative fees.

**ADMINISTRATION
for
CHILDREN and FAMILIES
Final FY 2004 Annual Performance Plan,
Revised Final FY 2003 Performance Plan,
and
FY 2002 Annual Performance Report
for the Government Performance and Results Act of 1993**

The Administration for Children and Families (ACF), within the Department of Health and Human Services (HHS), promotes the economic and social well-being of children, youth, families and communities, giving special attention to vulnerable populations such as children in low-income families, refugees, Native Americans, and the developmentally disabled.

February 2003

Office of Planning, Research and Evaluation
Administration for Children and Families
Contact Person: Mary Ann MacKenzie
(202) 401-5272

Web address: <http://www.acf.hhs.gov/programs/opre>



Dear Reader:

I am pleased to present the Administration for Children and Families' (ACF) FY 2004 Annual Performance Plan and the FY 2002 Annual Performance Report as required by the Government Performance and Results Act of 1993 (GPRA). Here you will learn where ACF stands in meeting a broad range of challenging goals that are directed toward improving child and family well-being by fostering independence and strengthening families. ACF's programs are carried out through partnership with the State, Territorial, local and Tribal governments, and with private, non-profit, faith- and community-based grantees.

The performance plan and report feature a comprehensive set of measures and outcomes in fifteen major areas providing results-oriented information that enables ACF to share with stakeholders its progress toward achieving four strategic goals:

- Increase economic independence and productivity for families,
- Improve healthy development, safety and well-being of children and youth,
- Increase the health and prosperity of communities and Tribes, and
- Manage resources to improve performance

ACF's implementation of performance management has created a consistent framework for linking agency-wide goals with program priorities and targeting resources to meet the needs of children and families. It has provided a shared vision of what needs to be accomplished with our partners. It provides a consistent and effective way to measure our achievements and to strive for continued improvement.

I hope you find it informative and useful.

Wade F. Horn, Ph.D.
Assistant Secretary
for Children and Families

TABLE OF CONTENTS

DEAR READER	iii
EXECUTIVE SUMMARY	vi
AGENCY MISSION AND STRATEGIC GOALS	vi
ORGANIZATION AND PROGRAMS	vii
OVERVIEW OF PLAN AND PERFORMANCE REPORT	ix
HIGHLIGHTS OF ACCOMPLISHMENTS	x
SUMMARY OF PERFORMANCE CHALLENGES	xiv
PROGRAM PERFORMANCE REPORT SUMMARY	xv
PART I: OVERVIEW OF PERFORMANCE MEASUREMENT	1
REPORT PLAN AND ROADMAP	1
LINKAGE WITH BUDGET	3
BUDGET CROSSWALK	4
PART II: MEASURE-BY-MEASURE PERFORMANCE	9
STRATEGIC GOAL 1: INCREASE ECONOMIC INDEPENDENCE AND PRODUCTIVITY FOR FAMILIES	9
1. INCREASE EMPLOYMENT	10
1.1 TEMPORARY ASSISTANCE FOR NEEDY FAMILIES: EMPLOYMENT	10
1.2 DEVELOPMENTAL DISABILITIES (GENERAL)	21
1.3 DEVELOPMENTAL DISABILITIES (EMPLOYMENT)	22
1.4 REFUGEE RESETTLEMENT	28
1.5 SOCIAL SERVICES BLOCK GRANT	39
2. INCREASE INDEPENDENT LIVING	44
2.1 DEVELOPMENTAL DISABILITIES (HOUSING)	44
2.2 ASSETS FOR INDEPENDENCE (INDIVIDUAL DEVELOPMENT ACCOUNTS)	47
3. INCREASE PARENTAL RESPONSIBILITY	52
3.1 CHILD SUPPORT ENFORCEMENT	53
4. INCREASE AFFORDABLE CHILD CARE	64
4.1 CHILD CARE: AFFORDABILITY	64
STRATEGIC GOAL 2: IMPROVE HEALTHY DEVELOPMENT, SAFETY AND WELL-BEING OF CHILDREN AND YOUTH	75
5. PROMOTE EARLY CHILDHOOD DEVELOPMENT	75
5.1 CHILD CARE: QUALITY	76
5.2 HEAD START	82
6. INCREASE SAFETY, PERMANENCY, AND WELL-BEING OF CHILDREN AND YOUTH	96
6.1 CHILD WELFARE	96
6.2 DEVELOPMENTAL DISABILITIES (EDUCATION)	105
6.3 DEVELOPMENTAL DISABILITIES (HEALTH)	107
6.4 YOUTH PROGRAMS	109
6.5 TEMPORARY ASSISTANCE FOR NEEDY FAMILIES: CHILD WELL-BEING	121
STRATEGIC GOAL 3: INCREASE THE HEALTH AND PROSPERITY OF COMMUNITIES AND TRIBES	124
7. BUILD HEALTHY, SAFE AND SUPPORTIVE COMMUNITIES AND TRIBES	124
7.1 COMMUNITY SERVICES BLOCK GRANT	125
7.2 FAMILY VIOLENCE PREVENTION PROGRAM	130
7.3 LOW-INCOME HOME ENERGY ASSISTANCE (LIHEAP)	138
7.4 NATIVE AMERICANS PROGRAMS	145
STRATEGIC GOAL 4: MANAGE RESOURCES TO IMPROVE PERFORMANCE	152
8. DEVELOP AND RETAIN A HIGHLY SKILLED, STRONGLY MOTIVATED STAFF	159
9. STREAMLINE ACF ORGANIZATIONAL LAYERS	162
10. IMPROVE AUTOMATED DATA AND MANAGEMENT SYSTEMS	163

11. ENSURE FINANCIAL MANAGEMENT ACCOUNTABILITY	165
APPENDICES TO THE PERFORMANCE PLAN	167
A.1 LINKAGE TO HHS AND AGENCY STRATEGIC PLAN	167
A.2 CHANGES/IMPROVEMENTS OVER PREVIOUS YEAR	170
A.3 PARTNERSHIPS AND COORDINATION	174
A.4 DATA VERIFICATION AND VALIDATION	176
A.5 PERFORMANCE MEASUREMENT LINKAGES	178
Information technology planning	178
Cost accounting	179
Workforce analysis plan	180
Program evaluation	180
A.6 FY 2001 PERFORMANCE DATA NOT REPORTED (PREVIOUSLY UNAVAILABLE)	184
A.7 DETAILED PROGRAM PERFORMANCE SUMMARY TABLE	189
A.8 AVAILABILITY OF STATE AND GRANTEE ADMINISTRATIVE DATA	191

EXECUTIVE SUMMARY

The Administration for Children and Families (ACF) supports a broad range of programs for children and families, helping them develop and grow toward independence and self-reliance. These programs, which are carried out by State, Territorial, county, city, and Tribal governments – as well as by private, nonprofit, community- and faith-based organizations – have been designed to promote stability, economic security, responsibility and self-sufficiency. ACF tailors its programs to meet the needs of a diverse cross-section of society, including low-income families, Native Americans, persons with developmental disabilities, refugees, legalized aliens, and other vulnerable populations.

ACF's FY 2004 Annual Performance Plan features a comprehensive set of measures and outcomes for the major programs. The combined FY 2004 Performance Plan and FY 2002 Performance Report identifies ACF's performance measures and provides results-oriented information that enables ACF to share with stakeholders its progress toward achieving its strategic goals.

Agency Mission and Strategic Goals

The mission of ACF is to promote the economic and social well-being of children, youth, families and communities, giving special attention to vulnerable populations such as children in low-income families, refugees, Native Americans, and the developmentally disabled.

To accomplish this mission, ACF strives to achieve the following four strategic goals:

Strategic Goal 1 – Increase economic independence and productivity for families: ACF assists families, particularly the most vulnerable, in achieving economic self-sufficiency and providing for their children's well-being. Key objectives include supporting job preparation and work, providing opportunities for independent living, ensuring parental responsibility, and offering child care subsidies targeted primarily to low-income families.

Strategic Goal 2 – Improve healthy development, safety and well-being of children and youth: ACF invests in opportunities for children and youth to enjoy stable, safe and healthy years of growth, enabling them to become successful learners and productive adults. Primary outcomes include healthy marriages, safe environments, school readiness, and positive youth development.

Strategic Goal 3 – Increase the health and prosperity of communities and Tribes: ACF believes that supportive communities and Tribes help families succeed. With its partners – including faith- and community-based organizations, private organizations, and State and local government – ACF is committed to supporting strategies that build strong, stable and supportive communities.

Strategic Goal 4 – Manage resources to improve performance: ACF believes that positive outcomes for individuals, families and communities can be achieved through building a more effective organization. The management objectives in this plan have been aligned with the President's Management Agenda and the HHS Strategic Plan. Major initiatives have been implemented in the areas of human capital, organizational development, electronic government and financial management.

Within the framework of these strategic goals, ACF's leadership has identified the following key priorities:

- **One Department:** Unifying systems, improving management of financial and physical assets, consolidating resources, eliminating duplication and restructuring the workforce to streamline and provide enhanced, citizen-centered services.
- **Prevention:** Dedicating resources to prevent the need for intervention services.
- **Rural Initiative:** Strengthening rural families and communities.
- **Enhancing Early Literacy of Children:** Improving the pre-reading and numeracy skills of young children to improve school readiness.
- **Next Phase of Welfare Reform:** Expanding welfare reform efforts to meet all four goals of the original legislation; identifying gaps and changes required to move the welfare reform agenda forward.
- **Positive Youth Development:** Promoting ongoing relationships with adult role models; safe places with structured activities; healthy life styles; opportunities to acquire marketable skills and opportunities for community service and civic participation.
- **Faith-based/Community Initiatives:** Removing barriers to the full participation of faith-based and other community services in the delivery of social services.
- **Healthy Marriage:** Helping couples who choose marriage for themselves to develop the skills and knowledge to form and sustain healthy marriages.
- **Fatherhood:** Helping men become responsible, committed, involved fathers.

These priorities have stimulated a variety of crosscutting, innovative strategies involving ACF programs, ACF Regional Offices, and their partners at the Federal, State, local and community level. Many of these strategies have led to the development of new performance measures that are reflected in this plan.

Organization and Programs

ACF is responsible for implementing twenty-two acts of legislation (which authorize more than sixty different programs), distributed among thirty-five budget activities. These program and budget activities are consolidated into 14 major program areas to meet the requirements of the Government Performance and Results Act of 1993 (GPRA). (Description of the linkage to the budget is described in Part I.)

- **Temporary Assistance for Needy Families (TANF)** block grant promotes work, responsibility and self-sufficiency and strengthens families through funding State- and Tribal-designed and administered programs. TANF-funded programs provide support to

needy children and move their parents into work (administered by Office of Family Assistance and Tribal TANF administered by the Office of Community Services).

- **Developmental Disabilities Programs** enhance the ability of persons with developmental disabilities to live, work and thrive in their communities through supporting State and other programs. These programs develop, coordinate and stimulate permanent improvement in service systems, with priority to those whose needs are not otherwise met under other health, education and human services programs (administered by Administration on Developmental Disabilities).
- **Refugee Resettlement** assists refugees and entrants who are admitted into the United States to become employed and self-sufficient as quickly as possible through grants to States and other grantees for employment-related services, social adjustment, transitional cash and medical assistance, and other services (administered by Office of Refugee Resettlement).
- **Social Services Block Grant (SSBG)** supports a variety of social services tailored to supplement State investments in the self-sufficiency and well-being of low-income populations. SSBG funds also help improve and integrate services, create community-based partnerships, and stimulate innovations (administered by Office of Community Services).
- **Assets for Independence Demonstration Program** establishes demonstration projects to determine the effects of providing an incentive to accumulate assets in individual development accounts to low-income individuals and families to increase their economic self-sufficiency (administered by Office of Community Services).
- **Child Support** locates parents, establishes paternity and support obligations and modifies and enforces those obligations to assure financial support is available to children. This work is done through State agencies that administer the program (administered by Office of Child Support Enforcement).
- **Child Care** provides grants to States to assist low-income working families who need safe, affordable and high-quality child care (administered by Child Care Bureau).
- **Head Start** provides comprehensive child development services to children and families, with an emphasis on each child's social and cognitive development and school readiness. Head Start programs offer support primarily for preschoolers from low-income families, through grants to local public and private nonprofit agencies (administered by Head Start Bureau).
- **Child Welfare Programs** fund State programs that assist at-risk children and their families in achieving safety, permanence, and well-being. These programs support preventive interventions to strengthen the family unit; foster care and adoption assistance to move children more rapidly from foster care to safe, permanent homes; and reunification services to return the child to the home if in the child's best interest (administered by Children's Bureau).
- **Youth Programs** support local agencies that provide shelter, improve life prospects, and reduce high-risk behavior and sexual abuse of runaway and homeless youth. These programs offer alternative activities, safe passages and the tools needed to move youth successfully to adulthood. A major focus is on disseminating best practices and building partnerships in areas of positive youth development (administered by Family and Youth Services Bureau).
- **Community Services Block Grant** provides an array of social services and programs through flexible block grant funding at the State and local level. The purpose of CSBG is to

assist low-income individuals and alleviate the causes and conditions of poverty (administered by Office of Community Services).

- **Family Violence Prevention Programs** support State and local programs and projects to prevent family violence and provide immediate shelter and assistance for the victims of family violence and their dependents. These programs are implemented through grants to States and State domestic violence coalitions for Battered Women's Shelters. Family Violence Prevention programs also support the Domestic Violence Hotline and national resource centers (administered by Office of Community Services).
- **Low-Income Home Energy Assistance (LIHEAP)** helps low-income families in covering the costs of heating and cooling their homes. LIHEAP achieves its mission through block grants and emergency contingency funds to States, Indian Tribes, and insular areas that target assistance to low-income households with high-energy burdens and vulnerable members (administered by Office of Community Services).
- **Native Americans Programs** promote economic and social self-sufficiency of American Indians, Alaskan Natives, Native Hawaiians, and Native Pacific Islanders by supporting programs and encouraging local strategies in economic and social development (administered by Administration for Native Americans).

The operations of these programs are carried out through central office headquarters (eight program and five staff offices) and through ten Regional Offices. By providing over \$45 billion in grants to governmental jurisdictions and nonprofit organizations and delivering technical assistance and oversight by approximately 1500 FTEs, ACF enables its partners to achieve results (ACF's partnerships are described in Appendix A.3).

Overview of Plan and Performance Report

ACF has organized its plan according to a standardized format issued by the Department of Health and Human Services (HHS). The Executive Summary provides general information describing the mission and goals of ACF, an overview of the FY 2004 performance plan and FY 2002 performance report, highlights of accomplishment and the program performance report summary table. Part I describes the report plan and provides a roadmap to the plan as well as information on the performance plan's linkages with the budget.

Part II includes a goal-by-goal section of each program activity. The FY 2004 performance plan and the FY 2002 performance report cover fourteen program areas as well as management initiatives with accompanying measures and targets under the appropriate ACF goals and objectives. Each program section includes a narrative description providing (1) the program purpose and legislative intent and (2) a summary table of measures, targets and performance information for FY 1999 – 2004. The reference column (fourth column) includes page references and identification of outcome measures that align with the HHS Strategic Plan and the President's Management Agenda. (U.S.). The total program-funding column in the summary table reflects the President's Budget for FY 2003, the requested FY 2004 Budget, and appropriated funds (aggregated by program area) for FY 1999 – 2002. (See Detailed Budget Linkage Table in Part I for line items included in each program total.)

The summary table is followed by a more detailed presentation of (3) program description and context including activities, strategies and resources and (4) program performance analysis. The program sections also include a budget table linking investments to activities, outputs and outcomes; a discussion of data issues; and performance measures for FY 2004 and revised final measures for FY 2003.

The Appendices include sections on linkage to HHS Strategic Plan; changes and improvements from the previous year including status of FY 2002 data and detailed changes between the FY 2003 plan and the revised final FY 2003 plan; partnerships and coordination; data verification and validation; performance measurement linkages, e.g., information technology, cost accounting, workforce planning and restructuring; program evaluation and budget; a detailed program performance summary table; itemization of new data reported for FY 2001; and a chart on the timetable for reporting State and grantee administrative data.

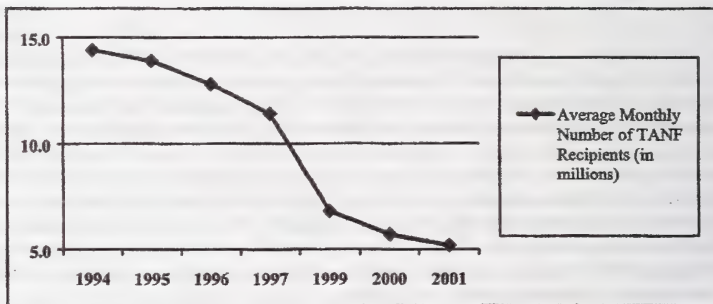
Highlights of Accomplishments

ACF helped to improve the economic independence of low-income families

In partnership with the States, ACF has achieved success in moving families from welfare to work. Much of this success can be attributed to the new relationships fostered by the 1996 welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).

PRWORA brought about a fundamental change in the nation's welfare system by ending the system of entitlements and requiring work in exchange for time-limited assistance. Under PRWORA, States, Tribes, and Territories receive block grants from ACF through the Temporary Assistance for Needy Families (TANF) program to cover benefits, administrative expenses, and services. TANF provides ACF's partners the flexibility to establish eligibility criteria, benefit levels, service types and resources available to TANF recipients.

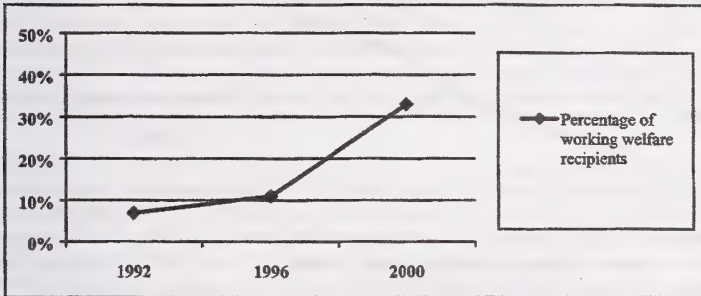
DECLINE IN NUMBER OF TANF RECIPIENTS, FY 1994-FY 2001



Source: TANF Administrative Data.

The partnerships have accomplished a great deal. For example, the average number of Americans receiving cash assistance each month has declined from 12.2 million in August 1996 to five million in June 2002 – a reduction of 59 percent. More current and former welfare recipients are entering the workforce. The percentage of working recipients remained at an all-time high for the second year in a row. In FY 2000, 33 percent of adult recipients were working, compared to less than seven percent in 1992, and 11 percent in 1996. Thus, about one in three recipients was working in a typical month, the highest level ever recorded. In FY 2000, the vast majority of recipients who were working were in paid employment (80 percent of those working); others were engaged in work experience and community service.

WELFARE RECIPIENTS IN LABOR FORCE, 1992- 2000



Source: AFDC/TANF Administrative Data.

However, the work has only begun. As ACF and its partners prepare for reauthorization and the next phase of welfare reform, a number of challenges remain. These include maintaining the TANF investment in order to reach needy families, promoting success at work, and transforming welfare offices.

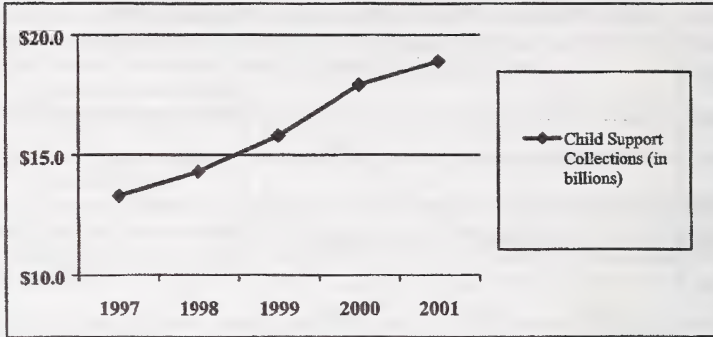
ACF increased parental involvement and financial support of non-custodial parents in the lives of their children

Despite the gains made under welfare reform to move individuals from cash assistance into work, employment represents only a part of the picture. Millions of American children grow up in single parent families and many of these families do not have awards or agreements for child support. Responding to this crisis, PRWORA created new opportunities for ACF to partner with Federal, State and local partners to identify and locate non-custodial parents and secure assets of those who have not supported their children.

PRWORA also created new opportunities for States to encourage two-parent, married families and reduce out-of-wedlock pregnancies. ACF is taking steps to link with State and local governments to increase investments that promote healthy marriage and responsible fatherhood.

Currently, 52 States and Territories are reporting data to the Federal Case Registry (FCR), which locates absent parents across State lines. The FCR contains 17.4 million child support cases. When absent parents are found, ACF promotes State use of the IRS tax refund and administrative offsets for child support. As part of the nearly \$19 billion collected for child support in FY 2001 (representing a 75 percent increase since 1997), a record \$1.5 billion in delinquent child support was collected in tax year 2001 using the tax refund and administrative offset. More than 2.1 million families benefited from these tax collections.

INCREASE IN CHILD SUPPORT COLLECTIONS, FY 1997-FY 2001



Source: OCSE Administrative Data.

The National Directory of New Hires provides another tool for identifying absent parents; it currently has 52 States and 146 agencies reporting data. During FY 2001 more than 879 million records were posted that matched child support orders to employment records with a value in excess of \$3.1 billion. In addition, ACF is operating the new multi-State financial institution data match system and is working with States to implement the in-State financial institution data match system to match delinquent parents with financial records.

ACF continued to promote access to quality child care services to help low-income working parents and their children

In order to break the cycle of poverty and dependency, it is essential to focus services on parents and their children. Parents are more likely to seek employment and maintain jobs if they have access to and confidence in their child care arrangements. ACF provides funding through the Federal Child Care and Development Fund (CCDF), TANF and the Social Services Block Grant (SSBG) for child care services. States are required to spend at least four percent of Federal CCDF to improve the quality of child care and offer additional services to parents. In addition, funds are earmarked for resource and referral services and school-age care, infant and toddler care, and additional quality improvement activities.

In FY 2001, States spent \$5.9 billion in Federal funds for child care (including significant amounts of funds transferred from TANF to CCDF) and approximately \$1.6 billion of their TANF block grants funds directly for child care services. In addition, \$2 billion in State funds, i.e., Matching and Maintenance of Effort, were spent under CCDF in FY 2001. In FY 2000, ACF estimates that in addition to the children served (1.75 million) with CCDF and CCDF-related funds, approximately 700,000 additional children received child care services through the Social Services Block Grant and TANF dollars spent directly on child care.

ACF improved the healthy development and learning readiness of pre-school children

Through its Head Start program, ACF continues to be a leader in providing comprehensive developmental education, health, mental health, nutrition, and social services for America's low-income, pre-school children and their families. Head Start's mission centers on promoting social competence and school readiness with an emphasis on literacy and numeracy. This year, more than 915,000 children will benefit from Head Start services. Research shows that Head Start increased the proportion of children who have the necessary cognitive and social skills to become successful learners.

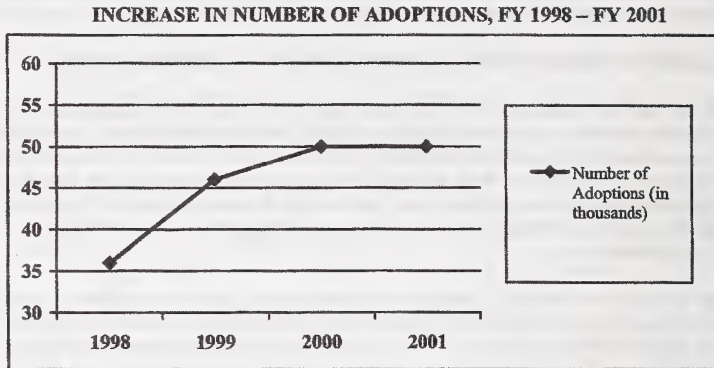
Research also provides encouraging results on program quality. Head Start classroom quality is good on average, with approximately 75 percent of over 500 observed classrooms rating good quality or higher on the Early Childhood Environment Rating Scale. The Family and Child Experiences Survey (FACES) showed encouraging results on program quality. Head Start classroom quality is linked to child outcomes. For example, children score higher on early literacy measures when they experience richer teacher-child interaction, more language learning opportunities, and a classroom well equipped with learning resources. This outcome, among others, is a proxy measure of the effectiveness of Head Start's national training and technical assistance network in which substantial funds are invested.

A key ingredient is a qualified teaching staff. Head Start's goal is to have 100 percent of its teachers with a degree in early childhood education (ECE), a child development associate credential, a State-awarded preschool certificate, a degree in a field related to ECE plus a State-awarded certificate or who are in CDA training and have been given a 180-day waiver. ACF maintains a high quality standard with between 85 and 95 percent of the teachers having the appropriate education. In FY 2003-2004, Head Start is implementing a major training initiative focusing on early literacy.

ACF increased the safety and security of children and youth

ACF is also making a difference through its programs to prevent maltreatment of children, protect children from abuse, and secure permanent placements for those who cannot safely return to their homes. Programs offered through ACF and its partners, such as Foster Care, Adoption Assistance, and Independent Living, provide stable environments. These programs strive to assure children's safety and well-being, while their parents resolve the problems which led to the out-of-home placement. Many times the best option for the child is to be placed permanently

with an adoptive family. ACF supports States and other partners in this effort through its Adoption Assistance funds, which are available for one-time payments for adoptions and for monthly subsidies to adoptive families. Due to these and related initiatives, ACF has recorded nearly a 100 percent increase in adoptions from FY 1995 to FY 2001.



Source: ACYF Administrative Data.

Summary of Performance Challenges

The diversity of programs, target populations, levels of government, and range of partners make efforts to establish and achieve goals and outcome measures extremely challenging. Over the past several years, ACF has changed the way it measures the success of programs and implemented a major shift in the way it does business with partners. A changing role with States and grantees has allowed ACF to accelerate major reforms in many programs. In order to focus on results, ACF continues to update performance measures, targets and information and strengthen partnerships with States and grantees. Creating a mature set of performance goals and data collection strategies is a high priority. It has taken considerable time to bring partners to the table, develop shared priorities and goals, address weaknesses in data collection and determine an optimum set of measures.

Data Issues: ACF relies on State administrative data systems for performance reporting because States and local community organizations administer most of its programs. For many programs, final reports are due ninety to 120 days after the fiscal year ends. In some cases, for example in TANF, where earnings gains are measured over a nine-month period after an individual obtains a job, the period is even longer. This time lag in receiving and validating data reports on actual achievements makes it difficult to provide a comprehensive summary of FY 2002 performance until late in FY 2003.

The lack of readily available information and the restrictions on data collection inhibit performance measurement. Additionally, many of ACF's performance metrics rely on voluntary data reports, e.g., LIHEAP, Child Care, TANF, CSBG, and ADD. Fluctuations in the number of States and grantees reporting and the flexibility allowed in selecting measures continue to make the collection of consistent, reliable and verifiable data extremely challenging. Detailed information on program-specific data issues and requirements for data validation and verification are addressed in each of the fourteen program sections. Appendix A.8 has detailed information on availability of State and grantee administrative data. ACF is currently working with the HHS Data Council to assess unmet data needs for its major programs.

Program Performance Report Summary: Accountability through Performance Measurement

ACF continues to make improvements in the performance measurement of its programs. As ACF gains experience in performance measurement, measures are being refined, added, dropped and replaced. As of January 2003, ACF is able to report on 56 of the 65 FY 2001 targets and 25 of the 70 FY 2002 targets. Missing FY 2001-2002 data will be reported in subsequent performance reports as they become available. The table below illustrates ACF GPRA performance progress for FY 1999-2002.

Performance Report Summary

Year	Total Measures	Measures Reported	Measures Met*	Unreported
2004	64 [4] ¹			
2003	56 [7] ²			
2002	70 [3] ³	25	12	45
2001	65 [3] ⁴	56	30	9
2000	52	52	26	0
1999	47	47	24	0

*Note: Includes performance, which is within five percent of estimated target.

For a detailed program performance summary table, please refer to Appendix A.7.

¹ Bracketed numbers indicate that measures are developmental; baselines will be established in 2004.

² Bracketed numbers indicate measures are developmental; baselines will be established in 2003.

³ Bracketed numbers indicate measures are developmental; baselines were established in 2002.

⁴ Youth program is unable to report on FY 2001 bracketed measures because of changes in data systems and definitions of measures.

PART I: OVERVIEW OF PERFORMANCE MEASUREMENT

Since the creation of GPRA, ACF has avoided developing a measurement system that emphasizes products, services and processes (inputs and outputs) and has embraced a system that emphasizes substantive outcomes. For FY 2004, ACF has strengthened performance management under GPRA. Recent efforts to link activities in each program area to objectives, measurable performance indicators, and targets with corresponding resources and strategies has taken us one step closer to integrating budgetary resources with outcomes.

Continued experience has improved the relationship between planned targets and actual results. Over time, the development of trend data has helped in setting and adjusting targets. In a few programs, such as TANF and child support, goal achievement is linked by program statute to incentives and sanctions. In these cases, the process has been driven by a concern for realistic targets. Where an incentives system is not a factor, programs have been encouraged to increase targets with the understanding that shortfalls in achievement will be informative for assessing whether targets have been set too aggressively and what corrective actions should be taken.

ACF's results orientation has encouraged programs to focus on achieving positive outcomes. This outcomes focus provides ACF with a framework for working with its partners, including local communities, non-profit organizations and States, to accomplish shared goals. In FY 2004, 48 of the 64 measures (75 percent) are outcome rather than process measures.

ACF has linked its performance measurement system with the HHS Strategic Plan and the President's Management Agenda (PMA) (see Appendix A.1 for linkage between the ACF plan and the HHS Strategic Plan). For FY 2004, all ACF measures align directly with the HHS strategic goals and objectives. The collaboration, coordination and integration of significant activities within the Department will result in improved services for individuals, families and communities. ACF has achieved substantial progress under all five of the PMA principles – strategic management of human capital, competitive sourcing, improved financial performance, e-government, and budget-performance integration. All four of ACF's management improvement measures align with PMA government-wide initiatives.

Report Plan and Roadmap

ACF's program efforts are carried out through partnership with the State, Territorial, local and Tribal governments, and with private, nonprofit, faith- and community-based grantees. ACF funds social research, demonstration programs and evaluation projects to develop reliable knowledge, support program policies, learn about effects on children and families, identify paths to program quality improvement, and discover better ways to conduct technical assistance, disseminate information, and deliver effective services.

Performance goals have been stated under the program sections that support the seven strategic program objectives and four management improvement objectives in this plan. This framework encourages individual programs to collaborate and direct their efforts to achieve crosscutting program goals and enables ACF partners to use the various program resources within ACF to focus on early childhood enrichment and the economic and social well-being of families. "Data

sources" under the various measures refer to OMB-approved program data collection instruments. The programs that support each of the goals and objectives are listed below:

Strategic Goal 1 – Increase economic independence and productivity for families

1. Increase employment

Temporary Assistance for Needy Families: Employment
Developmental Disabilities: Employment
Refugee Resettlement
Social Services Block Grant

2. Increase independent living

Developmental Disabilities: Housing
Assets for Independence

3. Increase parental responsibility

Child Support

4. Increase affordable child care

Child Care: Affordability

Strategic Goal 2 – Improve healthy development, safety and well-being of children and youth

5. Increase the quality of child care to promote childhood development

Child Care: Quality
Head Start

6. Increase safety, permanency, and well-being of children and youth

Child Welfare
Developmental Disabilities: Health
Youth Programs
Temporary Assistance for Needy Families: Child Well-Being

Strategic Goal 3 – Increase the health and prosperity of communities and Tribes

7. Build healthy, safe and supportive communities and Tribes

Community Services Block Grant
 Family Violence Prevention Program
 Low-Income Home Energy Assistance
 Native Americans Programs

Strategic Goal 4 – Manage resources to improve performance

- 8. Develop and retain a highly skilled, strongly motivated staff*
- 9. Streamline ACF organizational layers*
- 10. Improve automated data and management systems*
- 11. Ensure financial management accountability*

Linkage with Budget

ACF links performance measures to budget and accounting, as appropriate, to meet the requirements of GPRA. Under ACF's approach, more than 60 line-item programs have been aggregated and consolidated into 14 broad program activity areas. Selected program activities are aggregated in a single budget account, e.g., Temporary Assistance for Needy Families and Child Support Enforcement. Some program activities in more than one budget account are consolidated, e.g., Child Care and Child Welfare. Several activities remain free-standing, e.g., Head Start and Native American Programs. These program activity line items are aligned with corresponding strategic goals and objectives, enabling ACF to associate investments with specific achievements.

Consistent with the President's management initiative to strengthen the linkage between budget and program performance, ACF is implementing performance-based budgeting by highlighting the relationships between resource investments and activities at the program level and outcomes achieved by these activities in the longer term. This is the first time that each program description includes a table that links investments to activities and outcomes. This effort lays the groundwork for informing more effective, efficient decisions for resource allocation; improving internal management; and providing greater accountability through integrated financial and performance reporting.

ACF also encouraged programs to develop performance plans and reports that make a clearer connection between requested budgetary resources, planned activities and projected performance targets in the narrative sections.

Three ACF programs (Head Start, Office of Refugee Resettlement and Foster Care) were selected to participate in OMB's performance program assessments, a component of the President's budget and performance integration initiative. Information on the ratings for these three programs can be found in the appropriate program section in the Budget Justification.

ACF faces a number of challenges as it moves toward fuller integration. Among the most pressing challenges are:

- **The difficulty of linking budget with program outcomes:** Linkage can be made more directly to inputs, outputs and program activities.
- **The development of alternative budget scenarios and the selection of performance measures that drive programs toward improved performance:** Most ACF programs are administered by States and local communities so alternative budget scenarios, measures and targets must be useful at that level to improve performance.
- **Timely performance data for budget planning cycle:** Administrative data are not available and cannot be verified and reported until the second, third and sometimes not until the fourth quarter after the end of the fiscal year. Since the budget planning cycle for a particular fiscal year begins two years earlier, critical performance information is not available for budget planning purposes.

Budget Crosswalk

The budget crosswalk is a program-based account structure that allows ACF to assign resource investments to the agency's strategic goals based on the activities of the program line item. It identifies which strategic goal(s) each budget line item supports and includes selected performance measures.

A number of budget line items and their associated funds apply to more than one strategic goal or objective. To avoid duplicative counting, the dollar amounts are only associated with one appearance of their line item, usually where the associated measures most directly relate to the statutory purpose of the particular funding amount. In their appearances elsewhere, the dollar amounts are left blank and indicated with an asterisk. This table is for presentation and overview purposes, not for budgeting or performance analysis. The selected measures are representative and not intended to fully define the performance associated with the total budget under that category. A column has been added which identifies the budget program account number. Budget and other dollar figures are in millions.

NOTE: The budget linkage table below is not a formal budget presentation.

GPRA ACF STRATEGIC GOALS and OBJECTIVES				Detailed Budget Linkage Table							
With selected performance measures (Program Activity)				(not for budget analysis) (dollars in millions)							

PART II: GOAL-BY-GOAL PERFORMANCE MEASUREMENT

ACF's performance measures support the seven strategic program objectives and four management improvement objectives in this plan. This approach establishes a framework for individual programs to collaborate and direct their efforts to achieve ACF-wide crosscutting goals and enables ACF partners (State, Territorial, Tribal and local governments – as well as in private, nonprofit, faith- and community-based organizations) to invest program resources targeted on achieving shared outcomes.

ACF's performance goals align with the mission of HHS as reflected in the HHS Strategic Plan, as indicated in Appendix A.1. Performance data for the ACF goals have been supplemented as appropriate by information from program research and evaluation. Appendix A.6 provides a listing of selected evaluation projects.

STRATEGIC GOAL I: INCREASE ECONOMIC INDEPENDENCE AND PRODUCTIVITY FOR FAMILIES

RATIONALE

A family's capacity to lead a stable and productive life is enhanced by increasing economic independence and self-sufficiency. Achieving this goal requires assisting those in need to obtain and maintain employment within the context of work requirements and time-limited assistance. The job market, economic cycles, changing demographics, and patterns of family formation and child bearing affect outcomes under this goal. These economic and social factors influence parents' ability to find work, meet their family's needs and support obligations, and achieve self-sufficiency.

The President's welfare reauthorization proposal provides tools for ACF and its State partners to build on the successes of the 1996 reforms, including initiatives for demonstrations and research to promote healthy marriage, strengthen work participation requirements, and increase funding flexibility for States. Initiatives that promote responsible fatherhood, encourage the formation and maintenance of married, two-parent families, and prevent out-of-wedlock pregnancies are critical building blocks leading to greater family stability and self-sufficiency. Child support enforcement and affordable child care are critical to assuring that children are not living in poverty and that they are adequately cared for while their parents work.

The FY 2004 budget request for Unaccompanied Alien Children for \$34 million is a \$1 million increase over the FY 2003 budget. These funds will support the new programmatic requirements contained in section 462 of the Homeland Security Act protecting the rights and guaranteeing the well-being of unaccompanied alien children in the government's custody.

OBJECTIVES AND MAJOR PROGRAM AREAS**1. Increase employment**

Temporary Assistance for Needy Families: Employment
 Developmental Disabilities: Employment
 Refugee Resettlement
 Social Services Block Grant (SSBG)

2. Increase independent living

Developmental Disabilities: Housing
 Assets for Independence

3. Increase parental responsibility

Child Support

4. Increase affordable child care

Child Care: Affordability

1. INCREASE EMPLOYMENT

Approach for the Strategic Objective: Increase employment and economic independence by reducing reliance on public welfare programs, providing job training and other necessary supports and encouraging job creation. Focus on the abilities and skills of individuals, enabling them to move toward self-sufficiency and to pursue jobs in their communities.

1.1 TEMPORARY ASSISTANCE FOR NEEDY FAMILIES: EMPLOYMENT**Program Purpose and Legislative Intent**

The purposes of the Temporary Assistance for Needy Families (TANF) program are to provide assistance to needy families so that children can be cared for in their own homes; to reduce dependency by promoting job readiness, work and marriage; to prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. Title IV-A of the Social Security Act as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) requires that States and Territories operate programs, and Tribes have the option to run their own programs. States, Territories and Tribes each receive a block grant allocation with a requirement on States to maintain a historical level of State spending (for welfare) known as Maintenance of Effort (MOE). The block grant covers benefits, administrative expenses, and services. States, Territories and Tribes determine eligibility and benefit levels and services provided to needy families.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
1.1a. All States meet the TANF all-families work participation rates: FY 2002-2003 All families rate=50% work participation FY 2001 All families rate=45% work participation	FY 04: 100% FY 03: 100% FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%	FY 04: 9/05 FY 03: 9/04 FY 02: 9/03 FY 01: 100% FY 00: 100% FY 99: 100% FY 98: 100%	Px 18 HHS 6.1
1.1b. All States meet the TANF two parent families work participation rate of 90%	FY 04: 100% FY 03: 100% FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%	FY 04: 9/05 FY 03: 9/04 FY 02: 9/03 FY 01: 88% FY 00: 76% FY 99: 74% FY 98: 66%	
The reauthorization proposal replaces these two separate standards with a single participation standard for all cases with adults.			
1.1c. Increase (from the baseline year) the percentage of adult TANF recipients who become newly employed.	FY 03: 44% FY 02: 43% FY 01: 43% FY 00: 42% FY 99: NA	FY 03: 9/04 FY 02: 9/03 FY 01: 2/03 FY 00: 46.4% FY 99: 43.3% (42.9%) FY 98: 38.7%	Px 19 HHS 6.1
The number in parenthesis has been updated as a result of additional data.			
1.1d. Increase (from FY 2000) the percentage of adult TANF recipients/former recipients employed in one quarter of the year who continue to be employed in the next two consecutive quarters.	FY 03: 68% FY 02: 65% FY 01: 84% (64%) FY 00: 83% (63%) FY 99: NA	FY 03: 9/04 FY 02: 9/03 FY 01: 2/03 FY 00: 65% FY 99: 76.8%* (58%) FY 98: 80%*	Px 19 HHS 6.1
*For FY 98-99, this measure was limited to job retention over one subsequent quarter. The numbers in parentheses indicate what the rate was over two subsequent quarters for comparison purposes.			
1.1e. Increase (from the baseline year) the percentage rate of earnings gained by employed adult TANF recipients/former recipients between a base quarter and the second subsequent quarter.	FY 03: 29% FY 02: 28% FY 01: 28% FY 00: 27% FY 99: NA	FY 03: 9/04 FY 02: 9/03 FY 01: 2/03 FY 00: 25% FY 99: 27% (22%) FY 98: 24%	Px 20 HHS 6.1
The number in parenthesis for FY 99 was based on incomplete data and has been revised. The three measures 1.1c-e are being replaced in FY 2004 by the common measures which are in the chart below:			
1.1f. Increase the rate of case closures	FY 04: TBD FY 03: NA:	FY 04: FY 03: Baseline	Px 21

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
related to employment. (Developmental)			HHS 6.1
Total Funding (dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$17608.6 FY 03: \$19018.6 FY 02: \$17135.6 FY 01: \$16689.2 FY 00: \$16818.4 FY 99: \$17186.2	Bx: budget just. section Px: page # performance plan	

JOB TRAINING COMMON PERFORMANCE MEASURES (CPM)

There are presently more than 48 job training programs in 10 agencies. Although these programs vary considerably in the types of services provided and the target populations served, their common goal is to improve participants' employment and earnings. ACF and HHS have worked with the Office of Management and Budget, and the Departments of Labor, Education, Housing and Urban Development, Interior and Veteran's Affairs to develop a common set of measures for job training and employment for adults, youth and lifelong learning programs. The definitions and methodology for providing the TANF data for these measures are identified. Data for these three measures (entered employment, retention in employment, earnings increase) will be provided by Unemployment Insurance (UI) wage records and administrative records will be used for the efficiency measure. These measures will be adopted in FY 2004.

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
ENTERED EMPLOYMENT: 1.1c Percentage of adult recipients who become newly employed.	FY 2004: 44%	FY 2004	Px 19
Methodology: The numerator is "of those who receive TANF cash assistance in a quarter, the number who became employed in that quarter after being unemployed in the previous quarter." The denominator is "the total number of unemployed TANF cash assistance recipients from the previous quarter identified in the numerator".			
RETENTION IN EMPLOYMENT: 1.1d Percentage of those employed in a quarter that were still employed one and two quarters later.	FY 2004: 68%	FY 2004	Px 19
Methodology: The numerator is "of those who received TANF cash assistance and are employed in a quarter (Q-a), the number of adults who were employed one (Q-b) and two quarters (Q-c) later (regardless of TANF assistance status). The denominator is "the number of participants employed in Q-a.			
EARNINGS INCREASE: 1.1e Percentage change in earnings at	(a) FY 2004: (under development)	(a) NA	Px 20

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
two points in time: (a) Percent increase between first quarter of employment and the second quarter prior to receiving TANF assistance. (b) Percent increase in earnings between the third quarter of employment and the first quarter of employment.	(b) FY 2004: 29%	(b) FY 2004	
Methodology: (a) The numerator includes those who received TANF cash assistance with earnings from employment in a quarter (Q-a), their earnings in Q-a minus their earnings two quarters prior to being determined eligible for TANF cash assistance. The denominator is TANF cash assistance recipients' earnings two quarters prior to being determined eligible for TANF cash assistance. (b) The numerator includes those who received TANF cash assistance and who had earnings from employment in a quarter (Q-a), their earnings two quarters (Q-c) later minus their earnings in Q-a. The denominator is TANF cash assistance recipients' earnings in Q-a.			

PROGRAM DESCRIPTION AND CONTEXT

PRWORA dramatically changed the nation's welfare system into one that requires work while time-limiting assistance. The TANF program replaced the former Aid to Families with Dependent Children (AFDC), Job Opportunities and Basic Skills Training (JOBS) and Emergency Assistance (EA) programs, ending the Federal entitlement to assistance.

In FY 2003, the Administration seeks to reauthorize and fund the following pre-appropriated activities originally authorized under PRWORA as part of the TANF program at the levels included under current law: Family Assistance Grants to States, Tribes and Territories; Matching Grants to Territories; Bonus to Reward High Performance States; Tribal Work Programs; and the Contingency Fund. Supplemental Grants for Population Increases would be reinstated. In addition, a new fund supporting research, demonstration and technical assistance activities including family formation, healthy marriages, child welfare research and reducing the incidence of out-of-wedlock birth as well as a matching grant program on marriage promotion would be established.

ACF provides leadership to help States, Territories and Tribes as they design and implement their programs and move families from welfare to work, while protecting the well-being of children through child care and other services. PRWORA gives States flexibility to design their TANF programs in ways that promote work, responsibility, and self-sufficiency and strengthen families. The law limits the area that the Federal government may regulate, allowing States to use TANF funding in any manner "reasonably calculated to accomplish the purposes of TANF."

A primary goal of the TANF legislation is to move recipients from welfare to work and toward self-sufficiency. In addition to providing States with flexibility in program design and funding,

Congress established work participation performance standards and created a High Performance Bonus (HPB) incentive system to facilitate the achievement of this goal. PRWORA provides States and Territories both financial rewards for high performance and significant improvement and penalties for not meeting the work participation targets. The HPB legislation authorized awards for five years (FY 1999 – FY 2003). ACF issued award specifications for FY 1999, FY 2000, and FY 2001 through guidance. The first three years focused only on work measures, i.e., rates of newly employed recipients, retention rates and earnings gain rates of employed recipients and former recipients. Final rules were published in August 2000 to cover awards for FY 2002 and FY 2003. The Administration's reauthorization proposal restructures these grants to focus on employment achievement.

Under PRWORA, \$100 million in annual bonuses are awarded to as many as five States with the largest reduction in the proportion of out-of-wedlock births to total births. These bonuses are an incentive to encourage parental responsibility and the formation of two-parent families. ACF compiled the statistics reported by States and compared the proportion for the most recent two-year period to that for the preceding two-year period. For FY 2001, rankings were based on birth statistics from 1997 and 1998 compared to 1999 and 2000. In order to receive the bonuses, the States must also show a decrease in their abortion rate between the most recent year and 1995. Bonuses totaling \$100 million were awarded to Alabama, Colorado, Michigan, Texas, the District of Columbia and the Virgin Islands in September 2002. As part of the TANF reauthorization, the President has proposed eliminating these bonuses in order to focus efforts on the TANF goals addressing family formation and healthy marriage.

ACF selected outcomes that measure State investment and policy choices directed at supporting individuals to succeed at work. Strategic activities were developed to meet these targets including issuing bonuses to reward States for high performance; an aggressive technical assistance approach using contracts and grants; aggressive outreach and collaboration with key Federal and non-Federal partners; review and analysis of State programs and fiscal data to identify emerging trends; promoting and disseminating research results; and publishing regulations. Attention is being given to removing barriers to work for welfare recipients who are victims of domestic violence or have developmental disabilities or serious personal or family problems, such as substance abuse or mental health problems that interfere with their ability to work.

ACF implements a wide range of projects to help States and Tribes produce the desired outcomes. These projects include:

- Convening State and Tribal leaders to educate them about the specifics of the law and offering them the opportunity to engage other State or Tribal stakeholders designing their respective programs;
- Providing technical assistance through contracts and grants, including a Peer Technical Assistance Network that provides support to States, Tribes and localities to share expertise and proven experiences;
- Supporting initiatives to increase the availability of jobs for TANF recipients both in the private and public sectors, including Federal entry-level jobs;

- Developing a catalog and other sources of innovative practices, and convening workshops and conferences to provide targeted technical assistance;
- Sponsoring research and convening conferences to discuss welfare reform research; and
- Conducting and encouraging training on the need for welfare agencies to draw on the broader resources of other government agencies, the private sector, and community-based organizations.

To accomplish these strategies, ACF is training its employees in marketing, negotiating, and consulting; using and improving automated technology, databases, and electronic communication; and implementing team-based work procedures.

PROGRAM PERFORMANCE ANALYSIS

The central theme of the 1996 welfare reform legislation was moving families from welfare to work. ACF monitors State efforts in this critical area through two monitoring vehicles. States report detailed case level data on recipient participation in work or work related activities. States collect this information monthly and report it quarterly via the TANF Data Report system. ACF provides ongoing feedback to States on the participation rates they are achieving as well as information on the quality of their data. The second mechanism is through the HPB system. Although States' participation in this system is voluntary, forty-nine States and the District of Columbia provided FY 2000 performance data to compete in the FY 2001 HPB performance awards. This information is critical to understanding the nature and scope of employment activity of TANF recipients and former recipients.

Beginning with performance in FY 2001, the employment measures (job entry [newly employed], job retention and earnings gain) are based solely on performance data obtained from the National Directory of New Hires (NDNH). Under HPB specifications for performance years FY 1998, FY 1999 and FY 2000, States had flexibility in the data source(s) they used to obtain wage information on current and former TANF recipients. ACF moved to this single source national database (NDNH) to ensure equal access to wage data and uniform application of the performance specifications. Performance achieved for FY 2001 and 2002 may be affected by this change in data source. For example, States will have access to Federal employment wage data, which was not generally available before. On the other hand, changes in employment status during a quarter can not be identified in the quarterly wage data on the NDNH database whereas a State may have been able to identify employment status changes monthly through use of its administrative records.

Performance Report

Record numbers of people are moving from welfare to work. Retention rates are promising and all States met the overall work participation requirements in FY 2001. Since the August 1996 passage of the law, recipient caseloads are down by 59 percent. From December 2001 to June 2002, the number of recipients declined 5.1 percent from 5.27 million to approximately five million. These gains still leave too many clients without work or in entry-wage jobs, with below-poverty incomes that make it difficult to support families. Often, working parents lack the

necessary supports that will enable them to succeed in the workforce, such as access to affordable, quality child care, transportation, and training opportunities. Welfare reform has been less effective in addressing the needs of clients with multiple barriers to work such as inadequate fluency in English, mental health problems, addiction to alcohol or drugs, developmental and learning disabilities and domestic violence. Increasingly, State agencies are reporting that the proportion of clients with these barriers is growing.

ACF's ability to affect goal achievement is limited by the fact that much of the responsibility for welfare reform lies with the States and Tribes, and in a number of cases with counties and cities. ACF works in partnership with State, Tribal and local governments toward achieving the goal of increased employment for TANF recipients.

Employment Measures: Measures 1.1a-b—Congress established the TANF work participation performance targets for FY 1997 through FY 2002. In FY 2001, all fifty States, the District of Columbia and Puerto Rico met the overall work participation rates for all families. Of the 33 States, the District of Columbia and Guam that have two-parent family programs subject to a work participation rate in FY 2001, 30 States and the District of Columbia met the two-parent work participation rate standard of 90 percent. States have the option to move their two-parent cases into a separate State program thus avoiding the two-parent work participation requirements. The statutory two-parent participation target of 90 percent remains a rigorous standard.

Given the historic decline in the TANF caseload since 1994 (65 percent), individual State work participation targets are significantly lower than the national target rates. Beginning in FY 1997, the actual all-family and two-parent family participation rates achieved increased significantly each year until FY 2000, when there was an 11 percent decline in the national average rates. (Some of the decline in the all-family rate is attributed to the increase in the all-family minimum hours of weekly participation from 25 to 30 hours). Beginning in FY 2003, as part of the reauthorization proposal, a participation standard for all cases with adults would replace the two separate standards currently in existence. At least 50 percent of all cases receiving TANF that are headed by adults must be participating full-time in a simulated work-week of activities (40 hours per week) and at least 24 hours of these 40 hours must be in a traditional work activity.

The performance achieved by States in FY 1998 and FY 1999 under the job entry, retention, and earnings gain rate measures (measures 1.1c-e) reflect a major accomplishment. Data for these three measures were not collected under AFDC.

Measure 1.1c—In FY 2000 (the most recent year for which data are available), there was a 3.1 percentage point increase in the percent of adult TANF recipients who became newly employed (job entry). The success States had in moving TANF recipients to work in FY 2000 can be attributed to several factors. These include the employment focus of PRWORA, our commitment to research, identify and disseminate information on the effects of alternative employment strategies, a range of targeted technical assistance efforts, and a strong economy.

Measure 1.1d—There was a decrease of 7 percentage points in the percent of adult TANF recipients employed in one quarter who continued to be employed (employment retention) in the next two consecutive quarters (versus employment in the subsequent quarter). The actual performance for FY 1998 and FY 1999 was based on job retention performance over one quarter (TANF adult recipients/former recipients employed in one quarter of the year who were also employed in the following quarter). The FY 2000 targets for the work retention measure (1.1d) were established after the results from the first year of the HPB competition were calculated (FY 1998 performance data).

While ACF changed the work retention performance measure beginning with the third year of the HPB for FY 2000 and subsequent years to a more rigorous measure—from retention over two quarters to retention over three quarters, it did not change the performance targets. The final work retention rate for FY 2000 was 65 percent. The performance targets for FY 2002 and 2003 were calculated from a preliminary rate of 62 percent. ACF changed the projections for FY 2000 and FY 2001 based on these new calculations (63 percent and 64 percent).

Measure 1.1e—The FY 1999 performance was revised as a result of inclusion of new data from Nebraska and New Mexico. These States did not compete for the FY 2000 HPB awards, but provided FY 1999 performance data in order to compete for the FY 2001 work improvement measures which compare FY 1999 and FY 2000 performance information. There was a decrease of 2 percentage points in the percent rate of earnings gained between the base quarter and the second subsequent quarter (employment earnings gain rate). This decline could be the result of the change in the composition of the TANF caseload, i.e., recipients with less skills and fewer opportunities for increased wage rates or employment hours.

Trends: The performance measures and targets related to the work participation rates are statutory requirements for all States. From FY 1998 through FY 2001, all States met the all-families work participation rates. In the same time frame, there has also been a steady increase in the number of States meeting the more rigorous two-parent work participation rate (from 66 percent to 86 percent).

The remaining TANF work performance measures (job entry, employment retention and earnings gain rate) reflect the purpose of TANF and its ultimate goal of moving families to self-sufficiency. The job entry measure (measure 1.1c) has been steadily increasing from 38.7 percent in FY 1998 to 46.4 percent in FY 2000. One factor that may explain this increase is that States may have had access to more sources of data in the second year of operating TANF.

ACF's efforts are directed to provide leadership and incentives to States to accomplishing these outcomes. In a block grant environment, it is difficult to show direct linkages between Federal investments and outcomes at the State, Tribal, local and recipient level.

**BUDGET TABLE LINKING INVESTMENTS TO
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcomes
\$5,274,679 (OFA/OCS-Tribal Salaries, T&TA, Travel & Supplies)	Training & Technical Assistance	• Guidance • Program information • National conference • Workshops • Round-tables • Peer TA services and Web site • Program Web sites	• Increase the capacity of States and localities to meet the objectives of the TANF program • Inform and influence the Federal and State decision-making • Increase the number of tailored services for families
\$18,941,236 (OPRE TANF-related Research, Data Collection, Dissemination)	Research & Evaluation	• Demonstration projects • Grants • Data collection and analysis	• Increase the capacity of States and localities to meet the objective of the TANF program • Inform and influence the Federal and State decision-making • Increase the number of tailored services for families

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

Achieving economic independence for many TANF families begins with either direct job search or overcoming barriers to employment, e.g., lack of basic skills, and progresses to acquiring job experiences, a private sector job, increased wages, and eventually self-sufficiency. ACF believes that these three key elements: getting a job, retaining the job and increased earnings should be included as performance measures.

1.1a. FY 2003: All States meet the TANF all-families work participation rate of 50 percent.

FY 2004: All States meet the TANF all-families work participation rate of 50 percent.

1.1b. FY 2003: All States meet the TANF two-parent families work participation rate of 90 percent.

FY 2004: All States meet the TANF two-parent families work participation rate of 90 percent.

Congress established the work participation rates (measures 1.1a-b). The statute directs the Secretary to collect aggregated data (caseload summaries) and disaggregated data (by individual and family) on the TANF program quarterly. Note: The Administration's reauthorization proposal replaces these two standards with a single participation standard for all cases with adults.

The FY 2003 work performance measures (1.1c-e) were developed after extensive consultation with the American Public Human Services Association, the National Governors Association, and States as specified in the HPB statute. In FY 1999, ACF modified the work performance goal specifications to reflect percentage increase in performance rather than numeric changes and established modest increases in the target levels. The FY 2004 measures (1.1c-e) on entered employment, retention in employment, and earnings increase are the result of an effort to develop uniform evaluation metrics (common measures) with the Office of Management and Budget, Departments of Labor, Housing and Urban Development, Education, Veterans Affairs and Interior.

Beginning in FY 2001, the sole data source for these three measures is the NDNH that contains wage data from all State Employment Security Agencies as well as all Federal employment wage data. Previously States generated this data using multiple sources. This change in data source not only impacts the data reported for actual performance for measures 1.1c-e affect but also ACF's ability to do comparable projections from the previous year.

In light of pending reauthorization of the TANF program and the above-mentioned change in data source, ACF has established a conservative target for measure 1.1c, rather than projecting an increase above current performance, and has projected maintenance targets for measures 1.1d and e.

ENTERED EMPLOYMENT

1.1c. FY 2003: Increase (from the baseline year) the percentage of adult TANF recipients who become newly employed.

FY 2004: Increase (from the baseline year) the percentage of adult TANF recipients who become newly employed (CPM)

RETENTION IN EMPLOYMENT

1.1d. FY 2003: Increase (from FY 2000) the percentage of adult TANF recipients/former recipients employed in one quarter of the year who continue to be employed in the next two consecutive quarters.

FY 2004: Increase (from FY 2000) the percentage of adult TANF recipients/former recipients employed in a quarter that were still employed one and two quarters later. (CPM)

EARNINGS INCREASE

- 1.1e. FY 2003: Increase (from the baseline year) the percentage rate of earnings gained by employed adult TANF recipients/former recipients between a base quarter and the second subsequent quarter.**

For FY 2003, ACF looks at the earnings of those who are employed in each of the four quarters of the measurement year and determines if they are also employed in the second subsequent quarter. If they are employed in both quarters, ACF determines the gain in earnings (if any) between the initial quarter and the second subsequent quarter. The sum of these gains in earnings across the four quarters is the numerator. The denominator is the sum of the earnings in each of the four quarters in the measurement year.

FY 2004: The percentage change in earnings at two points in time by employed adult TANF recipients/former recipients. (CPM)

- (a) The percentage change in earnings between the first quarter of employment and the second quarter prior to receiving TANF assistance by employed TANF recipients/former recipients (under development).**

Plan for Obtaining Earnings Information Pre and Post TANF Enrollment: States do not currently collect employment/wage data on potential TANF participants before enrollment in the program. To obtain such information, ACF will develop recipient matching protocols in order to do a series of matches on the quarterly lists of adult recipients State currently provide to compete on the High Performance Bonus. These matches are necessary to identify TANF adult recipients who are recipients in the measurement quarter(s) but not in the previous two quarters. ACF will consult with States regarding their ability to provide recipient information for the prior quarters before enrollment. In order to implement this measure, ACF will modify the matching and wage compilation/calculation programs now used.

- (b) The percent increase in earnings between the third quarter of employment and the first quarter of employment by employed TANF recipients/former recipients.**

Data Sources: Unemployment Insurance (UI) Wage Records

The TANF measures, taken together, assess State success in moving recipients from welfare to work and self-sufficiency. Full success requires not only getting recipients into jobs, but also keeping them in those jobs and increasing their earnings in order to reduce dependency and enable families to support themselves. Caseload decline provides information on the number of families leaving TANF, but it does not indicate the number of families that are more self-

sufficient as a result of employment. Therefore, ACF is proposing a developmental measure (1.1f) that measures the rate of case closures related to employment, as well as the receipt of child support and marriage, which generally reflect the earnings of others.

ACF believes that this process measure is important because it encourages States to track how many recipients are leaving welfare as a result of getting jobs, receiving of child support and/or getting married and would focus welfare offices' capacity-building efforts on these efforts.

Developmental Measure

1.1g. FY 2003: Increase the rate of case closures related to employment, receipt of child support and marriage.

FY 2004: Increase the rate of case closures related to employment, receipt of child support and marriage.

Data Source: TANF administrative data

1.2 DEVELOPMENTAL DISABILITIES (GENERAL)

Program Purpose and Legislative Intent

The major goal of the Developmental Disabilities program is to assist people with developmental disabilities in reaching maximum potential through increased independence, productivity, inclusion, and community integration. ACF's program partners in the States work with State governments, local communities, and the private sector to reach goals relating to prevention, diagnosis, early intervention, therapy, education, training, employment, and community living and leisure opportunities. Activities are funded in eight areas: quality assurance, education and early intervention, child care, health, employment, housing, transportation and recreation activities. In ACF, the Administration on Developmental Disabilities (ADD) and its partners in the developmental disability (DD) community have the lead in pursuing these goals.

PROGRAM DESCRIPTION AND CONTEXT

There are nearly four million Americans with developmental disabilities. Developmental disabilities are severe, chronic disabilities attributable to mental and/or physical impairment, which manifest before age 22 and are likely to continue indefinitely. They result in substantial limitations in three or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Persons with developmental disabilities require individually planned and coordinated services.

ACF's DD grantee partners fall into four complementary groups. Each has a mandated mission to improve the lives of individuals with developmental disabilities and their families. Strategies must be non-duplicative, unique, and interlocking.

- **State Councils on Developmental Disabilities (SCDD)** pursue systems change, capacity building, and advocacy services in order to promote service systems and supports that are consumer- and family-centered, comprehensive, and coordinated. SCDDs employ strategies that include demonstration of new approaches, outreach training, public education, and information to policy-makers;
- **Protection and Advocacy (P&A)** systems in each State protect the legal and human rights of individuals with developmental disabilities. P&A strategies include legal, administrative, and other remedies; information and referral; investigation of incidents of abuse and neglect; and education of policy-makers;
- **University Centers for Excellence in Developmental Disabilities (UCEDDs)** are components of a university system or are public or not-for-profit entities associated with universities. These Centers provide interdisciplinary pre-service preparation of students and fellows, community service activities, and the dissemination of information and research findings; and
- **Projects of National Significance (PNS)** is a discretionary program providing ACF with the opportunity to focus funds on emerging areas of concern. This program supports local implementation of practical solutions and provides results and information for possible national replication. PNS also supports technical assistance; research regarding emerging disability issues; conferences and special meetings; and the development of national and State policy. Additionally, funding is provided for States to create or expand statewide systems change.

1.3 DEVELOPMENTAL DISABILITIES (EMPLOYMENT)

The DD employment goal is to increase competitive and inclusive employment for people with developmental disabilities consistent with their interests, abilities and needs. This goal encompasses issues such as vocational supports for students, career planning, and accommodation of disabilities. Strategies under this goal strive to create job choices and career opportunities that are integrated, accessible, equitable, and supported, and to inform employers of the capabilities of individuals with disabilities, and support practices and accommodations.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Increase entry into, and retention of, employment for people with developmental disabilities, consistent with their interests, abilities and needs.			
Objective: Increase employment of persons with developmental disabilities			
1.3a. Achieve the targeted number of adults with developmental disabilities who obtain integrated	FY 04: 7,815 FY 03: 6,834 FY 02: 3,850	FY 04: FY 03: FY 02: 3/03	Px 27 HHS

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
jobs as a result of DD program intervention.	FY 01: 3,800 FY 00: 9,517 FY 99: 9,517	FY 01: 5,854 FY 00: 3,788 (Rev. Baseline) FY 99: 8,959 FY 98: 9,665 FY 97: 6,945	6.1/ 6.3
1.3b. Achieve the targeted number of businesses/employers that employ and support people with developmental disabilities as a result of DD program intervention.	FY 03: Dropped FY 02: 1,400 FY 01: 1,350 FY 00: 4,353 FY 99: 4,353	FY 02: 3/03 FY 01: 1,813 FY 00: 1,324 FY 99: 1,113 FY 98: 1,198 FY 97: 824	Px 27 HHS 6.1/ 6.3
1.3c. Leverage the targeted dollars from ADD's Federal partners to support positive outcomes for people with developmental disabilities for employment, housing, education, health, and community support as a result of ADD intervention (dollars in millions).	FY 04: \$2.4 FY 03: \$2.4 FY 02: \$2.4 FY 01: \$2.4 FY 00: \$2.4 FY 99: \$3.5	FY 04: FY 03: FY 02: \$1.17 FY 01: \$1.1 FY 00: \$2.4 FY 99: \$2.1 (Baseline) FY 98: \$2.6 FY 97: \$2.6	Px 27
Total Funding (dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$140.4 FY 03: \$140.5 FY 02: \$140.5 FY 01: \$133.5 FY 00: \$122.2 FY 99: \$119.2	Bx: budget just. section Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

The programs in the States include three approaches to promoting employment. First, State Councils work to create systems change within employment service systems. Second, public and business opinions and attitudes concerning employment of persons with disabilities are improved through educational efforts, involving both the State Councils and the UCEDDs. Third, P&A systems strive to ensure that the rights of workers with developmental disabilities are not reduced. Interventions by State Councils include promoting job fairs, training job coaches, advocacy to employers to hire more people with developmental disabilities, and creating State-level entities that continue this work on an ongoing basis. Finally, funding in the PNS program is used to leverage other Federal resources.

Program Partnerships

Partnerships at the State and Federal levels represent the key to successful developmental disabilities programs. In the States, a major success factor stems from the interaction among developmental disabilities program grantees, sometimes referred to as the Developmental Disabilities Network. Additionally, each of these programs works with State and local entities, and the private sector, to achieve positive outcomes. At the Federal level, ACF coordinates with the Social Security Administration, the Department of Education, the Department of Labor, the Department of Transportation and other agencies. Within HHS, ACF works with CMS, HRSA and the President's Committee on Mental Retardation.

PROGRAM PERFORMANCE ANALYSIS

The first employment measure (1.3a) aligns closely with the President's New Freedom initiative, as it focuses on integrating individuals with developmental disabilities into the workforce. The other employment measure (1.3b) is being deleted in FY 2003. The Federal resources measure (1.3c) reflects ACF's capacity for engaging in crosscutting strategies and leveraging resources from other Federal agencies. Consequently, this measure will be important for ACF to track in order to develop other resources in support of the President's New Freedom initiative.

The instability in target and outcome data for measures 1.3a-b raises concerns: fluctuations in performance information from the State Councils are primarily related to the flexibility allowed under ACF's developmental disabilities programs and not to problems of reporting or the ability to achieve targets.

Federal law gives State Councils the opportunity to establish goals that reflect the needs in their respective jurisdictions. The dynamic nature of the planning environment makes it difficult for the State Councils to keep up with rapidly changing demands. The Councils strive to set targets in key areas for a five-year period, but are often forced to deal with year-to-year challenges affecting service delivery. For example, a State Council may target employment at the beginning of the planning period and shift directions and resources at mid-course due to changes in the economy, society or other factors. Such actions cannot be accurately predicted. The State Councils must constantly consider the competing demands for resources within the advocacy and service delivery communities. In some States, simply maintaining services and support systems at the current level can be a major accomplishment.

These conditions cause volatility in performance data and targets. Some of the difficulty in setting performance targets can be reduced by the use of trend data to stabilize performance; however, fluctuations will persist. ACF is taking steps to improve its reporting systems and set targets that take account of the changing dynamics within the States.

Performance Report

In FY 2002, all appropriated funding was made available to State Councils and P&A systems in the States. UCEDDs are currently in the process of having their applications reviewed for core funding. Under the PNS, funding is provided under the eight areas of emphasis. Additionally, projects are being advertised under the Family Support program. This program assists families of children with disabilities, including foster and adoptive families, to care for their children at home. To ensure the quality of programs, ADD has continued to fund technical assistance projects for its partners.

In FY 2001, the number of adults with developmental disabilities who obtained integrated jobs (measure 1.3a) was greater than the projected target and also greater than the previous year's performance. State Councils in 44 States and Territories reported 5,854 integrated jobs as a consequence of their intervention, 54 percent above the target of 3,800. States reported new project activities supporting the employment of persons with developmental disabilities.

The number of businesses/employers in FY 2001 that employ and support people with developmental disabilities (measure 1.3b) exceeded the target level. State Councils in 35 States and Territories reported 1,813 employers/businesses employing and supporting people with developmental disabilities, greater than the target of 1,350. This increase reflects national growth in employment in FY 2001 as well as the increased attention to employment issues by the State Councils.

In FY 2002, performance for dollars leveraged from ACF's Federal partners (measure 1.3c) was not met (\$1.17 million rather than the projected \$2.4 million was leveraged). The FY 2002 performance target was based on prospective funding opportunities that failed to generate the anticipated level of funding. In the future, ACF will seek out more reliable funding sources and will base its performance targets on these sources.

**BUDGET TABLE LINKING INVESTMENTS TO
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcomes
\$2.0 million (including \$0.9 million from non-ACF sources)	Training & Technical Assistance	Improved goal setting and enhanced strategic capacity	Higher achievement rates in high-need areas
\$20,000	Monitoring and Technical Assistance Review System (MTARS)	DD program compliance and identification of performance issues	Greater compliance with Federal law and improved quality of program activities, outputs and outcomes
\$340,000	Management of DD program reports and	Quality program information that is readily	Higher quality data to inform management

	information resources	accessible	decision-making
--	-----------------------	------------	-----------------

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

State Councils generate both target and outcome data for measures 1.3a-b, and 2.1a (see next section). The targets are reported by State Councils for a five-year period and updated annually. The current State Plans cover the period FY 2002—FY 2006. Outcome data for a particular fiscal year are reported in annual program performance reports (PPRs), submitted in January of the following fiscal year. Both the State Plans and the PPRs are submitted by the Electronic Data Submission (EDS) system.

Not all States set employment targets and many have begun focusing on other high-priority issues. The number of States that project targets and report on performance varies from year to year. ACF plans to correct this problem by working with every State to set some type of employment target resulting in 100 percent of States comprising the base for these measures. ACF plans in FY 2003 to encourage all DD program partners to track this measure and in FY 2004 to mandate setting and tracking ADD GPRA targets.

Various data sources are used to report on program targets and program outcomes, including annual program performance reports, planning reports, and administrative records. These sources are tracked through the EDS system. Interagency agreements and memoranda of understanding provide the data for the last measure, (measure 1.3c) "dollars leveraged," which is tracked in-house in ACF.

A database of the results from the EDS is used to compare targets and actual performance of ADD partners. Verification and validation of data occur through ongoing review and analysis of annual electronic reports, technical assistance site visits, and input from individuals with developmental disabilities, their families and other partners. When anomalies and variations in the data occur, ADD works with individual program partners to gain insight into the reason with assistance being provided by technical assistance contractors. Partners are encouraged to pursue corrective actions to ensure that data are valid.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Increase entry into, and retention of, employment for people with developmental disabilities consistent with their interests, abilities, and needs.

Objective: Increase employment of persons with developmental disabilities

- 1.3a. FY 2003: Achieve 6,834 adults with developmental disabilities who obtain integrated jobs as a result of DD program intervention.**

FY 2004: Achieve 7,815 adults with developmental disabilities who obtain integrated jobs as a result of DD program intervention.

Data Source: State Council annual Program Performance Report (PPR)

The targets for FY 2003 and FY 2004 are set by the State Councils and reported in their State Plans. They have been adjusted by ACF to spread the proposed increases over a two-year period. The targets are strategic in nature and are guides to courses of action rather than firm performance targets. They are influenced, not only by employment-related issues, but also by the full range of disabilities issues that compete for resources and attention. The proposed increases in targets are the result of employment emerging as a significant issue as evidenced by lengthy waiting lists for employment related services in many States.

Objective: Increase number of businesses/employers that employ persons with developmental disabilities

- 1.3b. FY 2003: Achieve the targeted number of businesses/employers that employ and support people with developmental disabilities as a result of DD program intervention. (Dropped)**

ACF has dropped measure 1.3b for FY 2003, since it is not as direct an outcome as the first employment measure 1.3a.

Objective: Maintain the Federal dollars leveraged across the spectrum of Federal programs to benefit persons with developmental disabilities

- 1.3c. FY 2003: Leverage \$2.4 million from ADD's Federal partners to support positive outcomes for people with developmental disabilities in terms of employment, housing, education, health, and community support as a result of ADD intervention.**

FY 2004: Leverage \$2.4 million from ADD's Federal partners to support positive outcomes for people with developmental disabilities in terms of employment, housing, education, health, and community support as a result of ADD intervention.

Data Source: ADD administrative records

1.4 REFUGEE RESETTLEMENT

Program Purpose and Legislative Intent

The purpose of the Office Refugee Resettlement (ORR) is to help refugees, Cuban/Haitian entrants, asylees and other special populations, as outlined in the ORR regulations, obtain economic and social self-sufficiency in the United States in the shortest time possible. ORR funding supports cash and medical assistance programs, English language training, employment preparation and job placement, skills training, social adjustment and other services to help refugees build new lives in the United States. As codified in the Refugee Act of 1980, Pub.L. 96-212, this program strengthened the United States' historic policy of aiding individuals fleeing persecution in their homeland.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
Long-term measure: By 2012, grantees will achieve an 85% entered employment rate (EER).			
1.4a. Increase the percent of refugees entering employment through ACF-funded refugee employment services by at least three percent annually from prior year. (Former Measure: Increase the number of refugees entering employment services by at least five percent annually from prior year's actual performance.)	FY 04: Increase 3% FY 03: Increase 3% FY 02: 48,188 FY 01: 56,885 FY 00: 54,176 FY 99: 51,597	FY 04: FY 03: FY 02: 4/03 FY 01: 45,893 FY 00: 48,820 FY 99: 50,208 FY 98: 52,298 FY 97: 46,800	Px 37 HHS 6.1
1.4b. Increase the percent of entered employment with health benefits available as a subset of full-time job placements by three percent annually from the prior year. (Former Measure: Increase the number of entered employment with health benefits available as a subset of full-time job placements by five percent	FY 04: Increase 3% FY 03: Increase 3% FY 02: 28,702 FY 01: 30,613 FY 00: 29,156 FY 99: 27,767	FY 04: FY 03: FY 02: 4/03 FY 01: 27,270 FY 00: 27,080 FY 99: 28,425 FY 98: 27,124 FY 97: 25,186	Px 37 HHS 3.1

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
Long-term measure: By 2012, grantees will achieve an 85% entered employment rate (EER).			
annually from the prior year's actual performance.)			
1.4c. Increase the percent of refugee cash assistance cases closed due to employment by at least three percent annually as a subset of all entered employment from the prior year. (Former Measure: Increase the number of refugee cash assistance cases closed due to employment by at least five percent annually as a subset of all entered employment from the prior year's actual performance.)	FY 03: Dropped FY 02: 14,934 FY 01: 18,169 FY 00: 17,304 FY 99: 16,480	FY 02: 4/03 FY 01: 14,223 FY 00: 15,539 FY 99: 16,445 FY 98: 16,978 FY 97: 14,948	Px 37 HHS 6.1
1.4d. Increase the percent of 90-day job retention as a subset of all entered employment by at least three percent annually from the prior year. (Former Measure: Increase the number of 90-day job retention as a subset of all entered employment by at least five percent annually from the prior year's actual performance.)	FY 04: Increase 3% FY 03: Increase 3% FY 02: 32,694 FY 01: 41,824 FY 00: 39,833 FY 99: 37,936	FY 04 FY 03: FY 02: 4/03 FY 01: 31,137 FY 00: 33,626 FY 99: 36,055 FY 98: 38,040 FY 97: 34,409	Px 38 HHS 6.1
1.4e. Increase the number of refugees who enter employment through the Matching Grant (MG) program as a subset of all MG employable adults by at least five percent annually from the prior year's performance.	CY 04: Increase 5% CY 03: Increase 5% CY 02: 14,576 CY 01: 9,504 CY 00: 9,051 CY 99: 8,620	CY 04: CY 03: CY 02: 7/03 CY 01: 13,882 CY 00: 10,931 CY 99: 9,713 CY 98: 8,049 CY 97: 7,819	Px 38 HHS 6.1
1.4f. Increase the number of refugee families (cases) that are self-sufficient (not dependent on any cash assistance) within the	CY 04: Increase 4% CY 03: Increase 4% CY 02: 10,860 CY 01: 6,176	CY 04: CY 03: CY 02: 7/03 CY 01: 10,442	Px 38 HHS

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
Long-term measure: By 2012, grantees will achieve an 85% entered employment rate (EER).			
first four months after arrival by at least four percent annually from the prior year's performance.	CY 00: 5,938 CY 99: 5,710	CY 00: 10,597 CY 99: 6,497 CY 98: 5,194 CY 97: 5,279	6.1
Total Funding (dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$462.6 FY 03: \$486.7 FY 02: \$493.9 FY 01: \$433.1 FY 00: \$426.2 FY 99: \$480.9	Bx: budget just. Section Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

ACF provides assistance and services to persons admitted to the United States as refugees, asylees, Cuban or Haitian entrants and Amerasian immigrants. The major program goals are to provide resources and technical assistance to States and other grantees in order to help refugees achieve economic self-sufficiency and social adjustment within the shortest time possible following their arrival in the United States.

Federal resettlement assistance to refugees is provided primarily through a State-administered refugee resettlement program. States provide transitional cash and medical assistance and social services to refugees, and maintain legal responsibility for the care of unaccompanied refugee children.

All California counties participating in the State-administered refugee resettlement receiving ORR social services or targeted assistance formula funds are required to submit an annual outcome goal plan. The California counties are heavily impacted by refugee resettlement and in some instances the California counties have more refugee arrivals than some States.

ORR provides funding for a broad range of social services to refugees, both through States and through direct service grants, to help refugees obtain employment and achieve economic self-sufficiency and social adjustment as quickly as possible. After deducting set-asides mandated by Congress, ORR, as in previous fiscal years, allocated 85 percent of the social service funds on a formula basis.

In June of FY 2000, ORR changed its policy regarding the start date for eligibility of asylees for ORR benefits and services from the date of entry into the United States to the date of the grant of

asylum. In FY 2001 this policy change added approximately 37,000 asylees to the ORR caseload eligible to receive cash and services. Adding the asylees to the refugee arrival ceiling (72,000) and entrant arrivals (19,000) increased ORR's total caseload to 128,000.

In FY 2002, the asylee policy change resulted in the addition of approximately 24,000 asylees to the estimated ORR caseload eligible to receive cash and services. Adding the asylees to the FY 2002 refugee arrival ceiling (70,000) and entrant arrivals (20,000) increased ORR's estimated FY 2002 caseload to 114,000. In addition, a new law passed in October 2000, the Trafficking Victims Protection Act (Pub. L. 106-386), made aliens who are victims of a severe form of trafficking in persons eligible for benefits and services under certain Federal or State programs to the same extent as refugees. For estimation purposes, ORR added 1,000 victims of a severe form of trafficking to the estimated FY 2002 caseload for a total estimated caseload of 115,000.

The Matching Grant program provides an alternative approach to the State-administered resettlement assistance. It provides voluntary agencies the opportunity to use focused intensive employment services, financial incentives, and the flexibility to experiment with creative solutions to the special employment problems of refugees in order to achieve early placements. The program's goal is to help refugees attain self-sufficiency within four months after arrival, without access to public cash assistance. This program provides comprehensive case management during enrollment and is targeted to families with at least one member deemed employable. Both of these features contribute to the high success rate for the CY 2001 performance in this program.

The definition of economic self-sufficiency – an integral component of the Matching Grant Program – is earnings/income for the total family at a level that enables a family unit to support itself without receipt of cash assistance.

ORR conducts on-site monitoring of selected States and other grantees to help them achieve improved client employment and self-sufficiency outcomes. ORR targets States that have large refugee populations and that receive significant ACF refugee program funding for monitoring. In monitoring, ORR assists States and grantees to identify strategies to improve outcomes on ORR performance measures and provides technical assistance on implementing program improvements.

Foreign policy decisions and crises affect the Refugee Program. ORR's ability to quickly resettle new arrivals depends not only on local job markets but also on the rate and number of refugee arrivals and refugees' special needs, educational levels, and English proficiency.

Program Partnerships

ACF refugee resettlement policies and activities are coordinated with the Department of State, State and community agencies, the Immigration and Naturalization Service, the Social Security Administration, the Department of Agriculture's Food and Consumer Service, as well as with TANF, Medicaid and other programs within HHS.

PROGRAM PERFORMANCE ANALYSIS

In FY 2001, 26 States did not meet their projected caseload target. The caseload consists of the number of refugees with whom a service provider had regular and direct involvement during the fiscal year in planned employment-related activities for the purpose of assisting the refugee to find or retain employment.

Some clients who request employment assistance receive services and in the midst of service provision find a job "on their own" but are unavailable or unwilling to share the employment information. Discrepant data are being reported for some cases because some States are struggling with identifying numbers of clients being served. For those employable clients receiving cash assistance, sometimes the assistance is reduced as a result of employment instead of terminated. In some States, more of the refugees served with ORR funding are hard to place and often need extensive longer-term assistance to find a job. ORR staff will continue to negotiate the goal setting process with partners to arrive at mutually acceptable goals and provide technical assistance where needed and program monitoring. Correcting discrepancies in data will be a priority.

Each year States are asked to set goals that represent continuous improvement over the previous year's performance. States that reach a high employment and self-sufficiency rate of 90 percent among employable refugees may establish goals to maintain that level of outcome instead of aiming for continued improvement. While States are encouraged to strive for continuous improvement, goal-setting is the result of a negotiation process.

National numbers do not tell the whole story. Many States significantly increased their performance, as indicated by the following analysis:

Entered employment: (Entered employment [job placements] is defined as the entry of an active participant in employment services into unsubsidized employment for at least one day during any quarter of the Federal fiscal year.) The number of job placements decreased by 6 percent in FY 2001. Nineteen States and four California counties exceeded their actual placements from last year. Eight States placed more than 90 percent of their caseload. Twenty-six States increased their FY 2002 target by five percent or more than their FY 2001 performance. Ten States met or exceeded the FY 2001 target they established.

Cash Assistance Terminations: (A cash assistance termination [grant termination] is defined as the closing of a cash assistance case due to earned income in an amount that is predicted to exceed the State's payment standard for the case based on family size, thereby rendering the case ineligible for cash assistance.) Twenty-two States and two California counties increased the number of cash assistance terminations over the previous year. Eight States met or exceeded the FY 2001 target they established. Twenty-four States increased their FY 2002 target by five percent or more of their FY 2001 performance.

Retentions: (This is a measure of continued participation in the labor market, not retention of a specific job. Employed means working for wages on the ninetieth day from placement at any unsubsidized job. Where there have been multiple placements for the same individual within the same Federal fiscal year, the date of the first employment entry is the start date for calculating the 90-day follow-up. An individual who is on strike on the ninetieth day is considered employed. An individual who has been laid off and does not anticipate returning to the same employment within 30 days is considered unemployed, unless the individual has obtained other employment.) Sixty-eight percent of refugees who found employment retained their employment for ninety days. Twenty-one States and five California counties improved the actual job retention rate over the previous year. In 31 States, more than 75 percent of job placements were retained for 90 days or more. Ten States met or exceeded the FY 2001 target they established. Sixteen States proposed increases in their FY 2002 target by five percent over their FY 2001 performance.

Entered Employment with Health Benefits: (Entered employment with health benefits available reflects the availability of health benefits [either at placement, or at any time within 6 months of placement] for those individuals who entered full-time employment. This is not a measure of how many individuals elect to enroll in health benefits, but rather how many jobs offer this option. Benefits should be considered available if self-only coverage is available to the employee, even if coverage is not extended to the employee's family members. Benefits are considered available without regard to whether the employee must contribute to the premium or whether the employee must wait for coverage.) Sixty-nine percent of full-time placements offered health insurance compared with 62 the year before. Twenty-one States and one California county increased their rates of health benefit availability over FY 2000. Ten States met or exceeded the FY 2001 target they established. Nineteen States increased their FY 2002 target by five percent or more of their FY 2001 performance.

FY 2001 showed significant improvement in the quality of jobs found for refugees. Thirty-eight States and eight California counties reported higher wages at placement than in FY 2000. Forty States reported average wage at placement of \$7.00 or above, compared with 36 in the previous year. Average wage at placement in the State-administered program was \$7.92, a four percent increase from FY 2000 (\$7.58).

FY 2002 performance will be affected by a number of significant events. The terrorist attacks of September 11, 2001 had a serious immediate impact on the Refugee Resettlement Program (RRP). After September 2001, the Federal Government suspended refugee arrivals to the United States until new security procedures were implemented for overseas screening. The President established the FY 2002 refugee admissions ceiling of 70,000 on November 21, 2001. However, refugee arrivals to the United States did not resume again with any regularity until April 2002. As a result of the suspension of refugee arrivals and the slow re-start of overseas refugee processing, ORR anticipates severely diminished refugee caseloads in all States and the Matching Grant during FY 2002. For example, as of March 31, 2002, only 7,283 refugees had arrived in the United States during FY 2002. In prior fiscal years, more than 40,000 refugees had arrived by the end of the second quarter, with larger numbers arriving in the third and fourth quarters. Since ORR targets derived from the estimated caseload were formulated based on

assumptions of a continuous flow of uninterrupted refugee arrivals, ORR anticipates that the FY 2002 targets will not be met.

Many refugees have lost their jobs as a result of the economic downturn in the hospitality industry immediately following the terrorist attacks of September 11. These newly unemployed refugees require re-employment, re-training and vocationally specific English language training in order to compete in the post-September 11 economy. ORR regulations make services available to refugees for their first five years in the United States. Many of the newly unemployed refugees have been in the United States for more than five years. In order to make employment services available to newly unemployed refugees who have been in the United States more than five years, the Director of ORR used his waiver authority to extend services to refugees who have been in the United States more than five years. Thus, ORR caseload for FY 2002 may be composed largely of previously served refugees, rather than new arrivals.

There are also a number of refugees, formerly victims of civil war and ethnic persecution, who were re-traumatized by the terrorist acts of September 11 and are in need of mental health services prior to seeking re-employment. For example, a large number of refugees were employed in the North Tower of the World Trade Center in Executive Dining Rooms and other restaurants. Many of the survivors are too traumatized to work and are receiving intensive counseling. Others are refusing to accept work in high rise buildings in Manhattan and are seeking jobs in small businesses that cannot support additional hires unless the economy improves.

Performance Report

Since FY 1995 ORR has been working in partnership with States to implement the requirements of GPRA into ORR's State-administered program. The joint effort to set annual performance targets has encouraged the State-administered program to shift to more of an outcome-oriented focus. ORR convened a workgroup comprising State Refugee Coordinators and ORR staff in November 1994 to establish performance measures and annual outcome goals. The workgroup agreed the selection of performance measures would be based on the following criteria: measures must be results-oriented, quantifiable, based on reliable data; stated in terms of positive change in social or economic conditions for the refugees using the services; and measure program effectiveness.

The workgroup also recommended that States be required to establish annual outcome targets aimed at continuous improvement of performance for each of the selected program measures. All performance measures focus on increasing refugee early employment and self-sufficiency. The workgroup recommended the following six program measures as most representative and manageable for reporting purposes. Four of the six measures have been incorporated in the ACF GPRA plan.

Since FY 1996, States (and California counties) have submitted an end-of-year report to ORR comparing projected annual targets with actual targets achieved for each of the six measures. States may include a narrative to explain increases or decreases in performance due to local

conditions that may have affected performance during the year. This includes labor market conditions or other factors, such as unanticipated reduction in refugee arrivals.

ORR tracks State and county performance throughout the year. Shortfalls in measures 1.4a-d have occurred because the targets were projected using five percent incremental increases from the FY 1997 baseline year rather than from the actual performance from the previous year. Additionally, these targets did not reflect the annual fluctuations in caseloads. Many States were unable to meet their projected targets because they failed to meet their projected caseload.

The FY 2001 performance was as follows:

Entered Employments: The FY 2001 goal for measure 1.4a was 56,885. The actual totaled 45,893, a six percent decline from the number recorded in FY 2000 (48,820).

Entered Employment with Health Benefits: The FY 2001 goal for measure 1.4b was 30,613. The actual totaled 27,270, a one percent increase from FY 2000 (27,080).

Terminations due to Earnings: The FY 2001 goal for measure 1.4c was 18,169. The actual totaled 14,223, an eight percent decline from FY 2000 (15,539). This measure will be dropped for FY 2003.

Employment Retention: The FY 2001 goal for measure 1.4d was 41,824. The actual totaled 31,137, a seven percent decline from FY 2000 (33,626).

CY 2001 Performance in the Matching Grant Voluntary Agency Program: The Matching Grant Program emphasizes family self-sufficiency (independence from cash assistance) and is characterized by a strong emphasis on early employment and intensive services during the first four months after arrival. The performance measures are focused on the two most critical program goals: entered employments and the proportion of cases that are self-sufficient at four months after arrival in the United States.

Entered Employments: The CY 2001 goal for measure 1.4e was 9,504. The actual totaled 13,882, a 30 percent increase from the number recorded in CY 2000 (10,931).

Self-sufficiency at 120 days: The CY 2001 goal for measure 1.4f was 6,176. The actual totaled 10,442 cases, a 69 percent increase (4,266) over the projected target.

ORR has implemented a number of strategies aimed at challenging States to improve performance for targets that were not achieved. ORR publishes State and Matching Grant performance results in the Annual Report to Congress; certificates of commendation are presented to States with increased performance at the annual ORR national conference; and ORR staff negotiate the targets and provide technical assistance and monitoring to the States and Matching Grant Program grantees to achieve mutually acceptable goals.

ORR continues to focus on performance and encourages grantees to set aggressive goals. ORR

negotiates annual goals with each of its grantees and stresses continuous improvement. The extent to which ORR can predict future performance is limited, because of the emergency humanitarian nature of the refugee resettlement program. Response to international mass migrations of persecuted persons, such as the asylees and the "Lost Boys" from Sudan, places additional demands on ORR's domestic resettlement partners by dramatically increasing the numbers of refugees receiving ORR services. However, ORR's service network continues to place large numbers of newly arrived refugees in jobs each year.

Data Issues

Data are submitted quarterly by all States participating in the State-administered program via the quarterly performance report (Form ORR-6). Data for the Matching Grant are submitted to ACF three times per year on the Matching Grant Progress Report form. Baseline data for all measures in the State-administered program were derived from FY 1997 annual unduplicated outcome data as reported on the annual Outcome Goal Plans through FY 2002. As of FY 2003, targets will be calculated based on the previous year's actual performance. Baseline data for the Matching Grant program are derived from the Calendar Year 1997 Report. Matching Grant unduplicated annual performance data are submitted to ACF in February of each year.

Desk monitoring and tracking of quarterly performance report data occur quarterly in the State-administered program and three times per year in the Matching Grant program. Data are validated by periodic on-site monitoring in which refugee cases are randomly selected and reviewed. During on-site monitoring, outcomes reported by service providers are verified with both employers and refugees to ensure accurate reporting of job placements, wages and retentions. In addition, States conduct regular monitoring of ORR-funded contracts and grants.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

ORR has established the long-term performance objective of achieving an 85 percent entered employment rate for the program by FY 2012. An entered employment rate (EER) is the ratio of refugees entering employment relative to the number of refugees receiving employment services, expressed as a percentage. ORR will measure annual performance against the following performance objectives: States with a FY 2002 EER of less than 50 percent will be expected to achieve a five percent annual increase in this performance rate. States with a FY 2002 EER of greater than 50 percent will be expected to achieve a three percent annual increase in this rate. States that reach a high employment and self-sufficiency rate of 90 percent among employable refugees may establish goals to maintain that level of outcome instead of aiming for continued improvement. Average national EERs will be calculated (a) for all States, (b) for all except the two States with the largest caseloads, and (c) for each of the two cohorts listed above. ORR expects to establish national performance objectives for each of these categories.

In the refugee State-administered program, FY 2003 and FY 2004 targets are calculated using a new baseline year of FY 2002. Starting in FY 2003, ORR performance goals and targets will be calculated as a percentage of caseload, as opposed to a raw number. Because States base their

employment targets on projected caseloads, an over-estimation may result in setting more aggressive targets for all measures in years of fewer arrivals, resulting in shortfalls. Therefore, entered employment targets will be calculated by dividing the unduplicated number of persons who entered employment by the number of persons in the actual unduplicated caseload to arrive at the percent of persons who entered employment. This calculation is the basis for setting future targets. ORR will not be able to provide the targets for these measures until the data are reported for each preceding year.

The Matching Grant program baselines use the calendar year to reflect the matching grant program period. FY 2003-2004, targets are projected using a four percent increase in the Matching Grant program on performance measure 1.4f. and a five percent increase for 1.4e and 3 percent increase for the State-administered program (measures 1.4a-c) from the previous year.

1.4a. FY 2003: Increase the percent of refugees entering employment through ACF-funded refugee employment services by at least three percent annually from the prior year.

FY 2004: Increase the percent of refugees entering employment through ACF-funded refugee employment services by at least three percent annually from the prior year.

In FY 2004, the entered employment goal will be calculated by determining the FY 2003 actual unduplicated number of persons who entered employment divided by the number of persons in the actual unduplicated FY 2003 caseload, to arrive at the percent of persons who entered employment. The target will reflect an annual increase of at least three percent from prior year's actual performance.

1.4b. FY 2003: Increase the percent of entered employments with health benefits available as a subset of full-time job placements by three percent annually from the prior year.

FY 2004: Increase the percent of entered employments with health benefits available as a subset of full-time job placements by three percent annually from the prior year.

In FY 2004, the entered employment with health benefits goal will be calculated by determining the percent of entered employment with health benefits available as a subset of full-time job placements. This percent will be increased by at least three percent annually from prior year's actual performance.

1.4c. FY 2003: Increase the percent of refugee cash assistance cases closed due to employment by at least three percent annually as a subset of all entered employment from the prior year's actual performance. (Dropped)

Measure 1.4c is being dropped since cash assistance terminations is not a significant measure for those refugees who re-enter the cash assistance rolls after initial employment and cash assistance termination. Also, early employment and cash assistance terminations, even if permanent, are uncertain measures of economic independence for families whose wage income is still too low to raise the family out of poverty.

1.4d. FY 2003: Increase the percent of 90-day job retentions as a subset of all entered employments by at least three percent annually from the prior year.

FY 2004: Increase the percent of 90-day job retentions as a subset of all entered employments by at least three percent annually from the prior year.

Data Sources: ORR-6.

In FY 2004, the employment retention goal will be calculated by determining the percent of 90-day retention as a subset of all entered employment. This percent will be increased by at least three percent annually from prior year's actual performance.

ACF requires nonprofit agencies participating in the Matching Grant Voluntary Agency Program to set outcome goals each year on five outcome measures negotiated with the Matching Grant agencies. Only the first two outcome measures are included in this annual performance plan and report.

- Entered employments (job placements)
- Self-sufficiency at 120 days (cases and persons)
- Self-sufficiency at 180 days (cases and persons)
- Average hourly wage at placement
- Entered employments with health benefits available

The following two sets of measures track progress for this program:

1.4e. FY 2003: Increase the number of refugees who enter employment through the Matching Grant (MG) program as a subset of all MG employable adults by at least five percent annually from the prior calendar year's actual performance.

FY 2004: Increase the number of refugees who enter employment through the Matching Grant program as a subset of all MG employable adults by at least five percent annually from the prior calendar year's actual performance.

1.4f. FY 2003: Increase the number of MG refugee families (cases) that are self-sufficient (not dependent on any cash assistance) within the first four months after arrival by at least four percent annually from the prior calendar year's performance.

FY 2004: Increase the number of MG refugee families (cases) that are self-sufficient (not dependent on any cash assistance) within the first four months after arrival by at least four percent annually from the prior calendar year's performance.

Data Source: Matching Grant Progress Report

1.5 SOCIAL SERVICES BLOCK GRANT

Program Purpose and Legislative Intent

The purpose of the Social Services Block Grant (SSBG) is to provide States with a flexible pool of resources to meet the changing needs of children and families. The program was established under title XX of the Social Security Act, as amended by Pub. L. 97-35. Funds are allocated to the States on the basis of population and support outcomes across the human service spectrum. SSBG outcomes align with several of ACF's strategic goals, including employment, child care, child welfare, adoptions and youth services. The SSBG resources give States the ability to target services in areas of greatest need, depending on State and local priorities. This reflects SSBG's guiding principles that States, local government, and communities are best able to determine the needs of individuals to help them achieve self-sufficiency, and social and economic needs are interrelated and must be met simultaneously.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PERFORMANCE GOAL: Increase economic independence and productivity for families			
1.5a. Increase by one percent the number of child recipients of day care services funded wholly or in part by SSBG funds over the previous year's performance. Note: This measure has been incorporated as part of the child care measure 4.1d.	FY 03: Dropped FY 02: Increase 1% FY 01: 2,399,827 FY 00: NA FY 99: NA	FY 02: 12/03 FY 01: 3,150,776 FY 00: 2,834,703 FY 99: 2,620,938 FY 98: 2,399,827 FY 97: 2,207,622 FY 96: 1,863,160 FY 95: 1,697,606	Px 43
PERFORMANCE GOAL: Increase the health and prosperity of communities			

1.5b. Increase by one percent the number of adult recipients of home-based services funded wholly or in part by SSBG funds over the previous year's performance.	FY 03: Dropped FY 02: 339,253 FY 01: 339,253 FY 00: NA FY 99: NA	FY 02: 12/03 FY 01: 260,937 FY 00: 467,478 FY 99: 506,707 FY 98: 339,253 FY 97: 259,464 FY 96: 258,828 FY 95: 279,497	Px 43
1.5c. Increase by one percent the number of adult recipients of special services for the disabled funded wholly or in part by SSBG funds over the previous year's performance.	FY 03: Dropped FY 02: 328,729 FY 01: 313,075 FY 00: NA FY 99: NA	FY 02: 12/03 FY 01: 912,661 FY 00: 974,587 FY 99: 708,129 FY 98: 298,167 FY 97: 470,723 FY 96: 317,101 FY 95: 243,931	Px 43
PROGRAM GOAL: Improve the healthy development, safety, and well-being of children and youth			
1.5d. Achieve at the FY 2003 baseline the number of recipients of child protective services funded wholly or in part by SSBG funds.	FY 04: Baseline FY 03: Baseline FY 02: 1,302,895 FY 01: 1,302,895 FY 00: NA FY 99: NA	FY 04 FY 03: Baseline FY 02: 12/03 FY 01: 1,411,427 FY 00: 1,081,446 FY 99: 1,312,736 FY 98: 1,302,895 FY 97: 1,037,860 FY 96: 1,147,397 FY 95: 1,100%,303	Px 44
1.5e. Increase by one percent the number of recipients of information and referral services funded wholly or in part by SSBG funds over the previous year's performance.	FY 03: Dropped FY 02: 1,348,171 FY 01: 1,321,736 FY 00: NA FY 99: NA	FY 02: 12/03 FY 01: 1,439,530 FY 00: 1,580,742 FY 99: 1,655,337 FY 98: 1,295,820 FY 97: 815,251 FY 96: 816,734 FY 95: 1,068,087	Px 44
Total Funding (dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$1700.0 FY 03: \$1700.0 FY 02: \$1700.0 FY 01: \$1725.0 FY 00: \$1775.0 FY 99: \$1909.0	Bx: budget just. section Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

States services funded by SSBG must be directed at one or more of five broad social policy goals:

- Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
- Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
- Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests or preserving, rehabilitating, or reuniting families;
- Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

Because of the flexibility provided States in using SSBG funds, expenditures vary across the States and even from year to year within each State. However, for many States service delivery across the human service spectrum would not be possible without SSBG funding. Particularly in the area of adult protective services, States have few options in gaining Federal support, and nearly half of the States using SSBG funds for this purpose receive approximately 75 percent of the funding from SSBG.

Moreover, these examples highlight not only the enhanced capacity given the States under SSBG, but also the crosscutting nature of ACF programs.

Program Partnerships

SSBG achieves its performance goals through partnerships at the national, State and local level. As stated, this ensures a more effective targeting of support to meet State- and community-level needs. However, such partnerships also raise considerable challenges for results-based management. The flexibility provided under SSBG removes many of the control and reporting mechanisms available under the non-block grant type of programs.

PROGRAM PERFORMANCE ANALYSIS

Expenditures of SSBG funds have declined consistently from FY 1997 to FY 2001, due to decreases in annual SSBG appropriations. In FY 2001, expenditures of SSBG funds were \$1.725 billion, which is 31 percent less than in FY 1997. In FY 1997, only two States reported expenditures of funds transferred from the TANF block grant; in FY 2001, 42 States reported such expenditures.

Performance Report

According to FY 2001 reports, States used \$2.663 billion for services that were funded by SSBG (of which 36 percent were funds transferred from TANF), with nearly 13 million individuals

served at least partially by SSBG resources. Of these individuals served, 7.4 million (58 percent) were children, and 5.4 million (42 percent) were adults. States spent the two largest portions of SSBG funds on child welfare for child protective services (\$314 million) and child foster care services (\$270 million).

SSBG's child protective services measure (1.5d) focuses on State activities to prevent or remedy abuse, neglect, or exploitation, and negligent treatment or maltreatment, including failure to be provided with adequate food, clothing, shelter, or medical care. Component services or activities may include immediate investigation and intervention, emergency medical services, emergency shelter, initiation of legal action (if needed), counseling for the child and the family and other services. Approximately \$314 million in SSBG funds were expended by 43 States in FY 2001 to serve 1.41 million children with protective services. States used more SSBG resources for child protective services in FY 2001 than for any other allowable service area.

SSBG funding also has enabled States to provide enhanced adult protective services. Thirty-two States reported spending \$151 million in FY 2001 in this program area, achieving a higher service level than otherwise possible since there are few Federal resources available for this purpose. The SSBG report in FY 2001 included data from 50 States and the District of Columbia.

The following table has been included to illustrate how ACF is investing FY 2002 resources to improve the efficiency and effectiveness of the Social Services Block Grant program.

**BUDGET TABLE LINKING INVESTMENTS TO
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcome
\$10,000	Develop data collection tools	Improved data collection	Accurate, valid data collections system
\$30,000	Revised report form and new instructions	Reduced number of discrepancies	Improved consistency of data

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

FY 2001 data are considerably more complete and accurate than data from prior years. Recently, ACF has taken steps, such as revising the post-expenditure form, to improve the clarity of reporting on services provided with these funds. The revised form and new instructions are intended to improve the consistency of reporting among States and reduce discrepancies in

reporting methodology. OMB has approved the revised reporting form, which will be used by States beginning with reporting for FY 2002.

SSBG data contain multi-year information and some of the dollars spent on services in FY 2001 may have been transferred from previous years or other programs. States report both total expenditures and SSBG expenditures. Total expenditures include all other Federal, State and local funds for each service that received SSBG funds. The complexity of many States' financial systems makes it difficult for them to provide accurate data on other sources of funds being applied to each of these services. Although all States submitted post-expenditure reports, many States were unable to provide information on total expenditures in their post-expenditure reports, so including this item would have excluded many more States from the analyses.

During this year, the Office of Community Services (OCS) assisted States in improving data collection and reporting. These data received from States are regularly validated. Problems arising through validation are discussed with States and technical assistance is provided where practical. While several problems exist, considerable improvement has been made to assist more States to report, and continuous progress is being made to increase validation rates and make the data more usable. OCS will continue to coordinate with other agencies and organizations to review and assess shifts in funding priorities in order to project accomplishment of ACF performance targets. ACF is committed to increasing the attention of States on more accurately reporting the results of their SSBG expenditures funded wholly or in part by SSBG funds.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Increase economic independence and productivity for families.

- 1.5a. FY 2003: *Achieve at the FY 2003 baseline level the number of child recipients of day care services funded wholly or in part by SSBG funds. (Dropped)***

This measure has been incorporated into the childcare measure 4.1d.

PROGRAM GOAL: Increase the health and prosperity of communities.

- 1.5b. FY 2003: *Increase by one percent the number of adult recipients of home-based services funded wholly or in part by SSBG funds over the previous year's performance. (Dropped)***
- 1.5c. FY 2003: *Increase by one percent the number of adult recipients of special services for the disabled funded wholly or in part by SSBG funds over the previous year's performance. (Dropped)***

The above measures tracked the number of adult recipients of home-based services and special services for the disabled. ACF is dropping these two measures to focus on the ACF program goal of improving the well-being of children.

PROGRAM GOAL: Improve the healthy development, safety, and well-being of children and youth

1.5d. FY 2003: *Establish a FY 2003 baseline for the number of recipients of child protective services funded wholly or in part by SSBG funds.*

FY 2004: *Achieve at the FY 2003 baseline the number of recipients of child protective services funded wholly or in part by SSBG funds.*

This revised measure will more accurately state the level of service delivery for child protective services under SSBG using the new FY 2003 baseline. As SSBG resources decline, the program strives to achieve the baseline standard performance.

1.5e. FY 2003: *Increase by one percent the number of recipients of information and referral services funded wholly or in part by SSBG funds over the previous year's performance. (Dropped)*

ACF is dropping this measure to focus on the ACF program goal of improving the well-being of children.

2. INCREASE INDEPENDENT LIVING

Approach for the Strategic Objective: Empower individuals with developmental disabilities to move into their own homes, increasing their personal control and participation in their community.

2.1 DEVELOPMENTAL DISABILITIES (HOUSING)

The DD housing goal is to increase the opportunities of adults with developmental disabilities to choose where and with whom they live and to have the services they need to support these choices. This goal encompasses issues such as having the opportunity to make choices about where to live and the ability to own their own homes, as well as basic principles of affordability and accessibility. ACF's DD housing measure will be critical to the President's New Freedom initiative that emphasizes providing support to families of children with disabilities so that they may care for and nurture their children at home. (See information on DD program purpose, legislative intent, and program partnerships under Strategic Objective 1, above.)

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Increase the opportunities of adults with developmental disabilities to choose where and with whom they live and to have the services they need to support these choices.			
Objective: Increase the number of people with developmental disabilities owning or renting their own homes.			
2.1a. Achieve the targeted number of people with developmental disabilities owning or renting their own homes as a result of DD program intervention.	FY 04: 4,015 FY 03: 4,015 FY 02: 8,000 FY 01: 7,500 FY 00: 2,132 FY 99: 2,079	FY 04: FY 03: FY 02: 3/03 FY 01: 4,013 FY 00: 7,308 (Rev. Baseline) FY 99: 34,904 FY 98: 19,649	Px 46 HHS 6.1/ 6.3

PROGRAM DESCRIPTION AND CONTEXT

As described under Strategic Goal 1, the State Council, the UCEDD(s), and the P&A system in each State contribute to pursuing housing for persons with developmental disabilities in accordance with State legislation. State Councils usually have the lead in promoting the development of housing options and their interventions include educating mortgage lenders, training potential homeowners and funding projects to demonstrate innovative practices to achieve positive outcomes.

PROGRAM PERFORMANCE ANALYSIS

The State Councils have the flexibility to focus on a broad array of DD issues. Trend analysis of achievement should increase ACF's ability to project future targets.

Availability of accessible housing is influenced by multiple factors in the environment. Primary factors include the impact of the economy on housing costs (owning and renting), the perceived cost of making housing accessible to people with disabilities, the impact of social attitudes regarding the desirability and potential for people with developmental disabilities to live freely in the community, and the negative attitudes of businesses and banks regarding making loans, selling homes, or renting to persons with developmental disabilities. All of these factors increase the difficulty for social services programs to provide access to DD housing.

Performance Report

(See information on DD program "Budget Table Linking Investments to Activities/Outputs/Outcomes" under Strategic Objective 1, above.)

State Councils in 32 States and Territories reported 4,013 people with developmental disabilities owning or renting their own homes (measure 2.1a), as a consequence of State Council intervention. This performance fell significantly short of both the FY 2000 actual and the FY 2001 target, which was based on the FY 2000 actual. This shortfall occurred in FY 2001 due to the need for States to target resources on other priority DD issues.

Data Issues

Many of the same data issues discussed in the context of DD employment measures affect the housing measure (2.1a). State Councils generate both target and outcome data for this indicator and submit target data to ACF via the EDS system as part of their Statement of Goals and Priorities (SGP) in the legislatively-mandated Program Performance Report (PPR), which is also submitted on the EDS system. Both the SGP and the PPR are submitted annually on January 1.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Increase the opportunities of adults with developmental disabilities to choose where and with whom they live and to have the services they need to support these choices.

Objective: Increase the number of people with developmental disabilities owning or renting their own homes.

2.1a. FY 2003: *Achieve 4,015 persons with developmental disabilities owning or renting their own homes as a result of DD program intervention.*

FY 2004: *Achieve 4,015 persons with developmental disabilities owning or renting their own homes as a result of DD program intervention.*

Data Source: DDC annual Program Performance Report (PPR)

As described earlier under Strategic Objective 1, targets for FY 2003 and FY 2004 are set by the State Councils and reported in their State Plans. The targets are strategic in nature and are viewed as guides rather than firm performance targets. Housing targets have been maintained due to competing program priorities in areas such as education, child care, health, employment, and transportation services provided by the State Councils.

2.2 ASSETS FOR INDEPENDENCE (INDIVIDUAL DEVELOPMENT ACCOUNTS)

Program Purpose and Legislative Intent

The purpose of the Assets for Independence Demonstration Program is to promote asset accumulation among lower-income working families as a tool to help them achieve self-sufficiency and enter the economic mainstream. The program provides incentives through matching contributions to investments of limited income working families in Individual Development Accounts (IDAs), which can be used for purchase of a first home, post-secondary education, or business capitalization. It was established by the Assets for Independence Act (AFI Act), under title IV of the Community Opportunities, Accountability and Training and Educational Services Human Services Reauthorization Act of 1998, Pub. L. 105-285.

The major goals of the program are to design demonstration projects that will determine (1) the social, civic, psychological, and economic effects of providing individuals and families with limited means an incentive to accumulate assets by saving a portion of their earned income; (2) the extent to which an asset-based policy that promotes saving for post-secondary education, homeownership and small business capitalization may be used to enable individuals and families with limited means to increase their economic self-sufficiency; and (3) the extent to which an asset-based policy stabilizes and improves families and the community in which they live.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
2.2a. The number of participants that have opened IDA accounts.	FY 03: Dropped FY 02: 5,389	FY 02: 6/03 FY 01: 4,037 (Baseline)	Px 52
2.2b. The number of participants receiving financial literacy education and asset-related training/services.	FY 03: Dropped FY 02: 5,945	FY 02: 6/03 FY 01: 4,453 (Baseline)	Px 52
2.2c. Increase acquisition of post-secondary education, homeownership and small business capitalization by low-income working families. (Developmental)	FY 04:	FY 04: FY 03: Baseline	Px 52 HHS 6.1

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
Total Funding (dollars in millions) See detailed Budget Linkage Table Part I for line items included in funding totals.	FY 04: \$24.9 FY 03: \$25.0 FY 02: \$24.9 FY 01: \$24.9 FY 00: \$10.0 FY 99: \$10.0	Bx: budget just. Section Px: page reference	

PROGRAM DESCRIPTION AND CONTEXT

The Assets for Independence Demonstration Program is a matched savings/investment program for lower-income individuals and families. Participants enter into a Savings Plan Agreement with the project grantee which establishes a schedule and goal of savings from earned income to be matched at an agreed rate which can be from one to eight dollars for each dollar saved. Matching contributions are made by the grantee at least quarterly from equal parts of Federal grant funds and non-Federal share contributions to the project. Matched savings may be expended for either (1) the purchase of a principal residence by a first-time homebuyer, (2) the capitalization of a business, or (3) the expenses of post-secondary education.

Competitive grants are made to eligible applicants, which include private, not-for-profit 501(c)(3) organizations; State and local governmental agencies or Tribal governments applying jointly with eligible not-for-profit organizations; credit unions that have been designated as Low Income Credit Unions by the National Credit Union Administration; and/or Community Development Financial Institutions (CDFI), so designated by the Treasury Department or the CDFI Fund.

This program is entering its fourth year of a five-year authorization, with the AFI Act scheduled to sunset at the end of FY 2003. It should be noted, however, that focus on the program will remain for several years following the sunset period, regardless of reauthorization. Projects funded at the end of FY 2003 will run through FY 2008. And Section 414(b)(5) of the Act calls for evaluation of "the potential financial returns to the Federal Government and to other public sector and private sector investors in individual development accounts over a five-year and ten-year period of time."

A first round of 40 demonstration grants was funded in August and September 1999 for 5-year demonstration projects. In FY 2000, OCS received another \$10 million appropriation with which it made 25 new competitive grants to new applicants and 17 supplementary grants to FY 1999 grantees. These supplementary grants were made to grantees that demonstrated their ability to raise additional non-Federal share dollars, that could document successful operation of their project so far, and that identified unmet need that could only be met with supplemental funding.

In FY 2001 OCS received an appropriation of \$25 million with which it made 78 competitive five-year grants: 58 to new applicants and 20 to existing grantees.

Financial literacy education and asset-specific training related to the savings goal are required elements of all AFIA-funded demonstration projects. They are critical to most participants' success in attaining assets and having them contribute to wealth accumulation over the long term. In addition, over 95 percent of AFIA projects provide some ancillary services, themselves or through referrals, to reinforce the ability of participants to achieve their savings goals. These can include employment support, childcare, transportation, credit repair, and crisis intervention services such as revolving loan funds that can help participants weather unexpected life events. Additional resources offered by many AFIA projects that help put the asset within reach include other financial support such as down payment assistance, special financing arrangements, and discounts or free services related to the purchase.

Each of these grantees will produce yearly progress reports within 60 days of completion of the project year. The Secretary will submit interim annual progress reports to Congress, using the information provided in these progress reports.

Program Partnerships

ACF works in partnership with selected States and local grantees toward achieving the goals of this program. ACF has found that a key to successful project implementation is the development of effective, mutually supportive relationships between grantees and their partnering financial institutions, and OCS technical assistance efforts focus on strengthening these relationships. Other external variables that will continue to influence the achievement of program goals include the health of the local economy and job availability; systemic barriers to employment such as availability of transportation and affordable day care; support of the banking, business, and foundation communities in providing non-Federal matching contributions; collaboration with other social service programs such as Weatherization Assistance and the Residential Energy Assistance Challenge Option Program (REACH), that can help to ensure the soundness and energy efficiency of dwellings purchased by IDA account holders; and the availability of support structures that enhance job retention and advancement of IDA program participants.

PROGRAM PERFORMANCE ANALYSIS

Strong evidence for the positive influence of asset ownership, particularly that of a home, business, or post-secondary education, is summarized in Dalton Conley's book, *Being Black, Living in the Red* (University of California Press: 1999). Based on data collected by the University of Michigan's Panel on Income Dynamics (PIDS), which contains data on over 68,000 households, Professor Conley demonstrated that asset ownership increases quality of life, intergenerational economic and educational performance, and family stability and reduces the likelihood of suffering adverse events, including involvement with the criminal justice system. Of note is the finding that asset ownership has a more powerful effect on life chances than racial or ethnic identity and social class.

ACF will assess the effectiveness of the IDAs based on evaluation research being conducted. (Note: Section 414(a) of the AFIA requires the Secretary to enter into a contract with an independent research organization for the purpose of a project evaluation.) The evaluation is entering its second year of site visits and participant interviews. A major focus of the evaluation involves looking at the economic, civic, psychological, and social effects of asset accumulation among lower income populations and communities. Within the framework of this overall impact assessment, the evaluation also explores the effects of project design, incentives, and institutional support on savings behavior; the savings rates based on demographic characteristics of participants; the effects of IDAs on participant achievement of asset goals; and other lessons to be learned from the funded demonstration projects, including whether a permanent IDA program should be established.

Achieving substantive impacts with IDAs takes considerable effort on the part of grantees. The concept itself must be fully explained, and high levels of program marketing, participant recruitment and program adaptation are required. Agencies administering IDA initiatives typically must revise outreach and intake strategies several times in order to find the right "marketing message" for their particular target population. This often entails conducting numerous focus groups and surveys with potential clients to identify the best way to explain the IDA account structure, program requirements, and recruitment expectations.

Performance Report

As of September 2001, grantees for FY 1999 and 2000 reported opening 4,037 IDAs and making a total of \$1,639,035 in savings deposits (2.2a). The 4,037 figure is the baseline for this performance measure. Given the fact that the income of most account holders was below 150 percent of poverty, these savings figures represent a substantial achievement by the grantees.

Financial and asset-related training was offered to 6,546 participants as of September 2001, with 4,453 participants completing their entire training program (2.2b). These two measures will be dropped effective FY 2003 as ACF moves toward a more outcome-oriented measure (see measure 2.2c below) based on participants actually completing their IDAs and acquiring their assets.

In their applications for funding, the FY 1999 and 2000 grantees cumulatively projected opening 7,584 IDAs during their five-year project periods. Although many grantees began the process of opening accounts within the first several months of the project, early research indicates that successful IDA programs generally undertake a thorough planning and preparation process prior to beginning participant recruitment – a process often requiring several months from initial outreach to the opening of accounts.

**BUDGET TABLE LINKING INVESTMENTS TO
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcomes
\$500,000	Mandated Evaluation	Evaluation Report	Program decision
\$950,000	Technical Assistance Prebid conferences and reports	Increase in number of applications and improved quality of projects	More efficient operation of projects, increasing efficacy of projects and higher successes among participants
\$600,000	Project monitoring and stewardship	Improved operation of projects	More efficient operation of projects, increasing efficacy of projects and higher successes among participants
\$400,000	Common Expenses and associated costs (GATES, PSC, office expenses)	Data and contract operations	Effective decision- making
\$22,540,000	Grant making	80 grants/year	Service to clients

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

The Assets for Independence Act allocates up to \$500,000 per year of the appropriated funds to evaluate the overall demonstration program in addition to the funds grantees are required to expend on data collection. The agency requires the grantee to provide a well thought-out plan for collecting, validating and reporting the necessary data in a timely fashion. The grantee is encouraged to identify the kinds of data it believes would facilitate the management information, reporting, and evaluation purposes. The grantee agrees to cooperate with the evaluation of the national program. Grantees are urged to carry out an ongoing assessment of the data and information collected as an effective management/feedback tool in implementing their project. OCS, through its technical assistance contractor, will provide all AFIA grantees with a new Asset Development Information System that will greatly facilitate maintenance, collection, validation, and transmission of project data essential to the program evaluation.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: To increase family stability and self-sufficiency through the accumulation of assets using a matched savings/investment program.

2.2a. FY 2003: *The number of participants that have opened IDA accounts. (Dropped)*

In FY 2003, the projects will have progressed sufficiently to provide significant numbers of participant achievements in completing IDA accounts. ACF is beginning to have measurable data and information on clients' progress toward these interim goals in their movement out of poverty, i.e., how many clients have completed their IDA accounts and how many have translated that into the acquisition of an appreciable asset. Still, these are interim outcome measures for account holders' achievement of economic self-sufficiency and entry into the economic mainstream. Consequently, ACF proposes dropping measure 2.2a in FY 2003.

2.2b. FY 2003: *Increase to 16,000 the number of low-income families receiving financial literacy and asset-related services. (Dropped)*

Measure 2.2b is being dropped because it measures the number of people receiving services rather than acquisition of education and/or assets as a result of their investment in IDA accounts.

Developmental Measure

2.2c. FY 2004: *Increase acquisition of post-secondary education, homeownership and small business capitalization by low-income working families.*

Data Source: Annual Progress Reports

With the completion of IDA accounts, the clients will have sustained themselves through a rigorous investment plan including the depositing of significant amounts of savings and will be primed for moving to the next step in the process of economic self-sufficiency. Account holders will have acquired an appreciable asset – a first home, a new business, or enrollment in post-secondary education (measure 2.2c). These assets have been demonstrated to increase quality of life, intergenerational economic and educational performance, and family stability, as well as to reduce the likelihood of the family suffering adverse events.

All these will have long term effects on their futures. Account holders will also have completed both financial literacy education and asset-specific training, which will enable them to deal more successfully with the complexities of banking and financial planning and the challenges of home ownership, business management and career planning.

3. INCREASE PARENTAL RESPONSIBILITY

Approach for the Strategic Objective: Establish paternity for children born out of wedlock and ensure that parents support their children.

3.1 CHILD SUPPORT ENFORCEMENT

Program Purpose and Legislative Intent

The mission of ACF's Child Support Enforcement (CSE) program is to assure that assistance in obtaining support is available to children by locating parents, establishing paternity and support obligations, and modifying and enforcing those obligations. The Office of Child Support Enforcement (OCSE) works in cooperation with State agencies to achieve these goals.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: All children have parentage established			
Objective: Increase the number of paternities established, particularly those established within one year of birth.			
3.1a. Increase the paternity establishment percentage (PEP) among children born out of wedlock. (This includes not only current paternity established cases but also completion of backlogs of older IV-D cases.)	FY 04: 99% FY 03: 98% FY 02: 97% FY 01: 96.5% FY 00: 96% FY 99: 96%	FY 04: FY 03: FY 02: 9/03 FY 01: 102% FY 00: 95% FY 99: 106%	Px 61 HHS 7.3
PROGRAM GOAL: All children in IV-D cases have financial and medical support orders.			
Objective: Increase the percentage of IV-D cases with orders for financial support.			
3.1b. Increase the percentage of IV-D cases having support orders.	FY 04: 70% FY 03: 67% FY 02: 64% FY 01: 62% FY 00: 76% FY 99: 74%	FY 04: FY 03: FY 02: 9/03 FY 01: 66% FY 00: 62% FY 99: 60%	Px 62 HHS 7.3
PROGRAM GOAL: All children in IV-D cases receive financial and medical support from both parents.			
Objective: Increase the collection rate.			
3.1c. Increase the IV-D collection rate for current support.	FY 04: 60% FY 03: 58% FY 02: 55% FY 01: 54% FY 00: 71% FY 99: 70%	FY 04: FY 03: FY 02: 9/03 FY 01: 57% FY 00: 56% FY 99: 53%	Px 63 HHS 7.3

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
<i>Objective: Increase paying cases.</i>			
3.1.d. Increase the percentage of paying cases among IV-D arrearage cases.	FY 04: 60% FY 03: 59% FY 02: 55% FY 01: 54.5% FY 00: 46% FY 99: 46%	FY 04: FY 03: FY 02: 9/03 FY 01: 59% FY 00: 57% FY 99: 55%	Px 63 HHS 7.3
<i>Objective: Make the process more efficient and responsive.</i>			
3.1.e. Increase the cost-effectiveness ratio (total dollars collected per \$1 of expenditures).	FY 04: \$4.35 FY 03: \$4.25 FY 02: \$4.20 FY 01: \$4.00 FY 00: \$5.00 FY 99: \$5.00	FY 04: FY 03: FY 02: 9/03 FY 01: \$4.18 FY 00: \$4.21 FY 99: \$3.94 FY 98: \$4.00	Px 64 HHS 7.3
Total Funding (dollars in millions)-Net Budget Authority * See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$3856.0 FY 03: \$3521.6 FY 02: \$3235.6 FY 01: \$3429.8 FY 00: \$3267.8 FY 99: \$2965.5	Bx: budget just. Sections Px: page # performance plan	
*These totals represent net Budget Authority and do not include obligation levels for Child Support Enforcement Programs.			

PROGRAM DESCRIPTION AND CONTEXT

ACF implements the child support provisions of the law through technical assistance, tracking parents, and helping collect court-ordered support payments. This strategy has been achieved through a variety of means, including implementing Federal policy, technical assistance, training, information dissemination, a more performance-based incentive funding structure, and Federal oversight and assistance with State-based quality assurance.

The CSE Program is federally funded, i.e., the Federal government pays 66 percent of State administrative costs and 90 percent of paternity laboratory costs, and the program is administered by State and local governments. The Federal role is to provide direction, guidance, technical assistance, oversight, and some critical services to States' CSE Programs for activities mandated under title IV-D of the Social Security Act. PRWORA provided new and effective tools for enforcing child support. These tools are having a significant impact on ACF's ability to collect support.

ACF continues efforts to broaden parental responsibility, especially the involvement of fathers in the lives of their children through several means: first, by focusing attention on the fathers' positive role in improving their children's well-being; second, by ensuring that ACF research agendas focus on the role of fathers in families and the effects of fathering on children's well-being; third, by using positive messages and language about fathers and fatherhood in publications and announcements; and finally, by ensuring that ACF's own workforce policies encourage and enable fathers to balance work and family life responsibilities.

Working in partnership with States, ACF will use the following resources and tools to achieve the FY 2004 performance goals:

- Federal match of State administrative expenditures (66 percent);
- Data Reliability Audits of performance data and related technical assistance provided to States by Federal auditors;
- All incentive funding to States will be based on State performance in paternity establishment, order establishment, current support collections, arrears cases paying and cost effectiveness;
- Section 1115 research grants, one percent and two percent set-aside funding to provide technical assistance, supportive contracts, and research and demonstration grants;
- Child access and visitation grants;
- Expanded Federal Parent Locator Service, including a database of new hires and child support cases to assist States to locate parents and obtain support through wage withholding;
- Federal Tax Refund/Administrative Offset program to offset income tax refunds and selected Federal payments to child support obligors;
- ACF central office child support (138) and regional office outstation (57) employees estimated at 195; and
- Central office child support staff are supplemented by approximately 145 contractor staff located both on- and off-site.

Program Partnerships

ACF has instituted several mechanisms to ensure internal and external coordination. Child Support reforms are being coordinated at several levels. OCSE was a GPRA pilot and many PRWORA reforms have been integrated into GPRA project activities. HHS has coordinated efforts to increase parental responsibility by promoting and encouraging father involvement through a fatherhood initiative that has representatives from all HHS agencies. Meeting regularly to foster coordination and collaboration across HHS, this group has established working relationships with many non-governmental groups working to promote fathers' involvement in the lives of children. The faith-based community has been contacted to help spread the word on parental responsibility, marriage and child support services.

OCSE has partnered extensively with a range of Federal agencies/programs and State and local entities. The Expanded Federal Parent Locator Service uses data from employers, State Child Support agencies, and State Employment Security agencies to implement the National Directory

of New Hires and Federal Case Registry. Treasury's Financial Management Service is a partner in the IRS Tax Refund Offset and the Administrative Payment Offset programs. The State Department is a partner in denying and revoking passports of individuals meeting certain delinquency criteria. OCSE has coordinated with numerous multi-State and in-State financial institutions to identify assets of non-custodial parents. OCSE has also collaborated with foundations, community-based organizations and State and local child support programs to launch demonstration projects in 10 sites to promote responsible fatherhood. These three year "fragile family" demonstrations, begun in March 2000, total \$15 million including \$10 million in Federal funding. Final evaluations will be available in FY 2005.

In order to direct more resources to holding non-custodial parents responsible, OCSE's Project Save Our Children (PSOC) partnered with the Department of Justice, U.S. Attorneys, the Federal Bureau of Investigation, the HHS Inspector General, and numerous State and local law enforcement agencies. OCSE reached out to the Department of Labor's Welfare to Work program to secure funds to benefit non-custodial parent job training. OCSE enlisted other ACF programs including Head Start, Foster Care and Child Care to educate clients about child support services. OCSE collaborated with the domestic violence community to inform service providers of the importance of child support and to ensure the safety of victims seeking child support services.

PROGRAM PERFORMANCE ANALYSIS

Welfare Reform: PRWORA is having a dramatic impact on the child support program. This law added major new responsibilities and increased workloads for both State and Federal staff. As described below, the CSE program has been greatly strengthened by the welfare reform law.

PRWORA provided new tools to the CSE program to secure emotional and financial support for many of the nation's children. Some of the new support enforcement tools are the National Directory of New Hires (NDNH), the Federal Case Registry (FCR), Financial Institution Data Matches, State Disbursement Units, activities in Paternity Establishment, and the Passport Denial program. PRWORA included significant enhancements of State and Federal data systems. States are now required to have a State Directory of New Hires and a State Case Registry for Child Support Enforcement. Together, the NDNH and the FCR give States the ability to track non-custodial parents across State lines using a complete and automated system. These various tools provided by the welfare reform law generate direct collections and also ancillary benefits. Some States are beginning to use matches provided by the system to locate custodial parents to distribute child support payments. The landscape of child support enforcement is changing because of the speed, efficiency, and effectiveness of this new system.

ACF and its partners use several reporting systems to facilitate this strategy. First, the Federal Parent Locator Service helps to locate non-custodial parents, as well as their employers and assets. This allows for establishing and enforcing child support orders. Second, the NDNH and FCR are operational and help to locate absent parents across State lines.

ACF works with the Department of State to deny passports to non-custodial parents who are not fulfilling their child support obligations. As many as 60 passports are denied every business day. Since the program's inception in June 1998, the States have collected more than \$14 million in lump sum payments. This amount does not include collections made through payment plans into which non-custodial parents enter upon denial of their passport.

ACF operates the Multi-State Financial Institution Data Match (MSFIDM) with financial institutions and works with State partners to implement the In-State Financial Institution Data Match that assists in identifying non-custodial parent assets. From January 1, 2002, through March 31, 2002, more than 1.8 million matches were returned from the multi-State financial institutions, based on matching social security numbers. As of December 2001, more than 4,500 financial institutions are participating in the MSFIDM. States are using arrangements including in-house, consortia, and outsourcing to implement the in-State financial institution data match with local financial institutions.

Project Save Our Children, an initiative on criminal child support enforcement, has succeeded in its pursuit of chronic delinquent parents who owe large sums of child support. Since the project's creation in 1998, multi-agency regional task forces have received more than 4,250 referrals, resulting in 486 arrests, 421 convictions and civil adjudications, and court orders to pay more than \$16 million in owed child support.

Incentive funding: The CSE program includes an incentive funding system with a formula based in statute. PRWORA required the Secretary to develop a new revenue-neutral, performance-based incentive funding formula in consultation with the States. The old incentive funding system, which paid rewards to States based on cost-effectiveness was in effect until FY 2001, when a new system, enacted by the Child Support Performance and Incentive Act of 1998 (CSPIA), was phased in beginning in FY 2000.

For FY 2001, States were able to earn one-third of what they earned under the traditional cost-effectiveness formula. Two-thirds of the \$429 million FY 2001 incentive pool was available to all States to be shared under the performance-based incentive formula. The formula continues to be instrumental in driving the CSE program toward achievement of its performance targets. This performance plan employs the same five performance measures enacted by CSPIA:

- **Statewide paternity establishment percentage (PEP)**

Number of Children in State with Paternity Established or Acknowledged during the FY
Number of Children in State Born Out-of-Wedlock in the Preceding FY

- **Percentage of IV-D cases with support orders:**

Number of IV-D Cases with Support Orders
Number of IV-D Cases

- **IV-D collection rate for current support:**

Collections on Current Support in IV-D Cases
Current Support Amount Owed in IV-D Cases

• **IV-D arrearage cases paying:**

Number of IV-D Cases Paying Toward Arrears
Number of IV-D Cases with Arrears Due

• **Total dollars collected per \$1 of expenditures:**

Total of IV-D Dollars Collected
Total of IV-D Dollars Expended

To implement the new incentive system, OCSE has trained States on the incentive measures, the formula for calculating payments and revised data reporting. OCSE's auditors are closely monitoring the ability of States to report reliable data and are also assessing the validity of State-reported data. Data reliability audits for FY 2001 began in January 2002 and were completed in August 2002. OCSE performs an analysis of the data and compiles a preliminary data report each summer. Final incentives were calculated in September 2002.

Performance Report

The OCSE Audit Division has completed all FY 2001 data reliability audits and issued final reports for all States. For FY 2000 actual data, the reliability standard was 90 percent, but for FY 2001 the standard increased to 95 percent. ACF has greater confidence in the data for actual performance at this higher standard. The FY 2001 data shown below are final.

Paternities (measure 3.1a): The number of children born out of wedlock with paternity established or acknowledged in FY 2001 is approximately 1.6 million, providing a Statewide paternity establishment percentage of 102 percent (this includes backlogs of older IV-D cases). The target is 96.5 percent. ACF will continue to provide technical assistance, early interventions, training and education activities to help individuals better understand their parental responsibilities.

Support Orders (measure 3.1b): In FY 2001, approximately 11 million cases had support orders established out of 17.2 million IV-D cases (66 percent). This reflects an increase of three percent over the previous year (approximately 10.7 million support order cases out of 17.3 million IV-D cases were established). The FY 2002 target was increased based on the actual performance in FY 2000. PRWORA has provided States with administrative authority and other means of more effectively establishing orders, and more States are moving to administrative procedures as opposed to court orders. Further, PRWORA requires that all States enact the Uniform Interstate Family Support Act, a model State law for interstate cases, which allows them to establish orders against non-residents. These strategies will help OCSE improve performance. State staffing levels remain about the same while IV-D caseloads with support orders continue to increase

slightly, making this target difficult to increase. Thirty-two States increased their caseload in FY 2001. ACF anticipates conducting assessments to provide recommendations to States on appropriate staffing levels.

Collections on Current Support (measure 3.1c): The total amount of child support distributed as current support in FY 2001 was \$14.2 billion, approximately a ten percent increase from FY 2000. The total amount of current support due in FY 2001 was \$24.7 billion, which is approximately a seven percent increase from FY 2000. This provides a collection rate for current support of 57 percent. The FY 2002 target was increased based on the actual performance in FY 2000. OCSE is committed to achieving a higher performance level by focusing on improved enforcement techniques and ensuring more reliable data. Particular emphasis will be placed on automated mechanisms for enforcement, collections, and payments to families. These efforts have been enhanced by PRWORA, which provides States with new hire reporting, uniform procedures for interstate cases, centralized collection and disbursement, and enhanced wage-withholding procedures.

Cases Paying Toward Arrearages (measure 3.1d): There are 10.3 million cases with arrearages due in FY 2001 which is a four percent increase from FY 2000. Total cases paying toward arrearages is 6.1 million in FY 2001, a nine percent increase from FY 2000. This provides a percentage of paying cases among IV-D arrearage cases of 59 percent. The FY 2002 target was increased based on the actual performance in FY 2000. OCSE will focus on improved enforcement techniques emphasizing automated mechanisms for enforcement, collections, and payments to families.

Collections (measure 3.1e): In FY 2001, collections reached a record high of \$19 billion, a six percent increase from the previous fiscal year. The inter-State collections totaled \$1.2 billion.

Expenditures (measure 3.1e): Under the Child Support Performance and Incentive Act cost effectiveness ratio, the national ratio is \$4.18 in FY 2001. The collections distributed (\$19 billion), inter-State collections (\$1.2 billion), and fees retained by other States (\$14.3 million) total \$20.1 billion. The administrative expenditures (\$4.8 billion), less the non-IV-D costs (\$14.5 million), total approximately \$4.785 billion in FY 2001. States have increased administrative investments in automated data processes (up seven percent in FY 2001). These expenditures are expected to continue to increase in future years to improve the efficiency of State programs through automated systems. State administrative expenditures are included in Federal audits.

In summary, new collection tools and program improvements, such as new hire reporting and increasing Statewide automation, have increased collections but they have not been fully implemented in all States. Performance targets for FY 2003 and 2004 for all five measures will increase from FY 2002.

The following one percent and two percent table has been included to illustrate how ACF invested FY 2001 resources to improve the efficiency and effectiveness of the Child Support Enforcement program at the State and local community levels.

**BUDGET TABLE LINKING INVESTMENTS
TO ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcomes
1% Budget			
\$3,800,000	Research, demonstration & special projects	Grants	Increased knowledge
\$5,515,000	Training & technical assistance	State/Tribal outreach	Increased program knowledge
\$1,410,000	Information dissemination	Printing of material	Information sharing
2% Budget			
\$20,100,000	Expanded Federal Parent Locator (eFPLS)	Matched computer records	Increased collections
\$2,136,000	Research & demonstration	Grants	Increased knowledge
\$1,200,000	Project Save Our Children	Criminal enforcement	Increased collections

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

State Automated Systems: States currently maintain information on the necessary data elements for the five program measures. Most States use an automated system to maintain these data, while a few maintain the data manually. All States were required to have a comprehensive, Statewide, automated CSE system in place by October 1, 1997. Fifty-two States and Territories indicate compliance with the single statewide child support enforcement automation requirements of the Family Support Act of 1998. Fifty States are FSA-certified, two States have been reviewed but their certification review report hasn't been issued yet. Forty-seven States indicate compliance with PRWORA. Continuing implementation of these systems, in conjunction with cleanup of case data, will improve the accuracy and consistency of reporting.

Data Completeness and Reliability. As part of OCSE's review of performance data, the State's ability to produce valid data will be reviewed. Data reliability audits are conducted annually. Self-evaluation by States and OCSE audits will provide an on-going review of the validity of data input and the ability of automated systems to produce accurate data. There is a substantial time lag in data availability. The Audit Division completed the FY 2001 audits as of August 2002.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

The achievement of performance targets will be significantly affected by a number of factors interacting with the CSE program in ways that either help or hinder performance goal achievement including: (1) the effect of State TANF program structures and policies; (2) the five-year time limit on TANF benefits which leaves child support as even more critical for family self-sufficiency; (3) the national economy; (4) wage and unemployment rates; and (5) demographic and social trends such as divorce and non-marital birth rates. These and other external factors impact State agency caseloads, paternity establishment workloads, and ability to collect support payments.

States have organized their enforcement systems and infrastructures differently. Through its considerable national and regional technical assistance initiatives, many incorporating State self-assessment and peer technology transfers, ACF is customizing its efforts to individual State needs. Additionally, the new performance-based incentive process will add impetus to those States that may need to assign a higher priority to child support programs.

The program objective statements listed below are part of the OCSE's multi-year Strategic Plan aimed at increasing overall performance.

PROGRAM GOAL: All children have parentage established.

Objective: Increase the number of paternities established, particularly those established within one year of birth.

3.1a. FY 2003: Increase to 98 percent the paternity establishment percentage (PEP) among children born out of wedlock.

FY 2004: Increase to 99 percent the paternity establishment percentage (PEP) among children born out of wedlock.

Data Source: The OCSE Form 157 is the source of data needed to calculate this measure.

This measure directly indicates achievement of the performance target by comparing paternities established during the fiscal year with the number of non-marital births during the preceding fiscal year. The statute allows States to use the IV-D PEP or a Statewide PEP. The Statewide PEP was selected because most States indicated they would use the Statewide PEP as well. The rates above include paternities established by both the IV-D program and hospital-based programs. Increasing the target rate in FY 2004 requires States to keep up with establishing paternities on out-of-wedlock births while continuing to handle backlogs of older IV-D cases needing paternity established.

Early interventions will be sought through expanding hospital-based paternity establishment programs and partnering with birth record agencies, pre-natal clinics and other entities and encouraging voluntary acknowledgments, in accordance with the requirements of PRWORA. Partners will work together with customers to help both parents understand their parental responsibilities and to promote establishing paternity in a non-adversarial manner wherever possible. In collaboration with partners and stakeholders, ACF will explore a variety of activities to help individuals better understand their parental responsibilities, including contributing to direct education programs in high schools, counseling, public awareness campaigns, public service announcements, and brochures about the CSE program.

PROGRAM GOAL: All children in IV-D cases have financial and medical support orders.

Objective: Increase the percentage of IV-D cases with orders for financial support.

3.1b. FY 2003: Increase to 67 percent the percentage of IV-D cases having support orders.

FY 2004: Increase to 70 percent baseline the percentage of IV-D cases having support orders.

Data Source: The OCSE Form 157 is the source of data needed to calculate this measure.

A support order is needed to collect child support. This measure directly indicates achievement of the performance target by comparing the number of IV-D cases with support orders with the total number of IV-D cases. ACF projects a slight increase in the target rate for FY 2004 based on the FY 2000 actual of 62 percent. This will require more effort as new child support cases are added to State workloads each year, increasing the overall caseload needing services.

PRWORA gives States new tools to establish an order more quickly, such as administrative authority to require genetic testing, subpoena financial and other information, and to access a wide array of records. More States are voluntarily shifting from establishing court-based orders to administrative-based orders. PRWORA requires expedited administrative procedures for establishing orders; expands paternity acknowledgment programs to birth record agencies, setting the stage for order establishment; and requires that all States enact the Uniform Interstate Family Support Act which grants States expansive long-arm jurisdiction allowing them to establish support orders against non-residents, thus avoiding the lengthy two-State process.

Medical Support Performance

The Child Support Performance and Incentive Act of 1998 requires the Secretary of HHS to recommend a medical support indicator for inclusion in the new incentive system. The Secretary's report to Congress in June 1999 recommended postponing the development of an indicator. OCSE is working with the States to develop the medical support indicator. The indicator workgroup submitted its recommendations and report in 2001.

PROGRAM GOAL: All children in IV-D cases receive financial and medical support from both parents.

Objective: Increase the collection rate.

3.1c. FY 2003: Increase to 58 percent the IV-D collection rate for current support.

FY 2004: Increase to 60 percent the IV-D collection rate for current support.

Data Source: The OCSE Form 157 is the source of data needed to calculate this measure.

This measure, a proxy for the regular and timely payment of support, directly indicates achievement of the performance target by comparing total dollars collected for current support in IV-D cases with total dollars owed for current support in IV-D cases. OCSE is projecting small increases in the performance targets for FY 2003 and 2004.

Focus will be placed on improved enforcement techniques emphasizing automated mechanisms for enforcement, collections and payments to families. ACF will emphasize improving the numerous processes that result in the support of children. These improvements include: (1) simplifying the payment process; (2) reducing barriers to non-custodial parents providing support payments; (3) increasing the number of cases handled using automated systems; (4) using alternative disposition strategies such as consensual agreements and other non-judicial agreements; (5) improving interstate case processing; (6) increasing coordination and integration of services with other agencies; and (7) increasing access to services.

Objective: Increase paying cases.

3.1d. FY 2003: Increase to 59 percent the percentage of paying cases among IV-D arrearage cases.

FY 2004: Increase to 60 percent the percentage of paying cases among IV-D arrearage cases.

Data Source: The OCSE Form 157 is the source of data needed to calculate this measure.

This measure directly indicates achievement of the performance target by comparing the total number of IV-D cases paying any amount toward arrears with the total number of IV-D cases with arrears due. More direct measurement of a national arrearage collection rate is impossible because States have laws that count arrears in widely varying ways. Some new cases enter the caseload with arrearages already accrued before the State can take any action. This measure, developed by the State/Federal Incentive Formula effort, has been incorporated into the revised FY 2000-2004 Strategic Plan.

Obtaining payment of arrears is often difficult. States must collect both current support and any accrued arrearages. Non-custodial parents often cannot keep up with both current support and arrears, hence arrears payments suffer. Focus will be placed on improved enforcement techniques emphasizing automated mechanisms for enforcement, collections and payments to families.

As stated above, OCSE is projecting increases in performance targets for FY 2003 and 2004. Trend data indicate that arrearage in caseload is increasing which makes achieving these targets all the more challenging.

Objective: Make the process more efficient and responsive.

3.1e. FY 2003: Increase the cost-effectiveness ratio (total dollars collected per \$1 of expenditures) to \$4.25.

FY 2004: Increase the cost-effectiveness ratio (total dollars collected per \$1 of expenditures) to \$4.35.

Data Sources: The OCSE Form 34A and 396A are the source of data needed to calculate this measure.

This measure directly indicates achievement of the performance target by comparing total IV-D dollars collected by States with total IV-D dollars expended by States. Increasing the target rate for FY 2004 requires greater effort because State caseloads and the total amount of child support owed increase each year. For example, in FY 2001, the IV-D caseload increased slightly but the total amount of arrearages due for all fiscal years increased by 11.3 percent.

Under current law, cost effectiveness is being phased out as the sole determinant for incentive payments. It is important to monitor the allowable costs of the program in relation to the amount collected. Focus will be placed on increased efficiency of State programs through automated systems of case management, enforcement, collection and disbursement; staffing, administrative processes and increased collections resulting from approaches described previously under current collections; and arrears cases paying.

4. INCREASE AFFORDABLE CHILD CARE

Approach for the Strategic Objective: increase access to affordable, quality child care for low-income, working families.

4.1 CHILD CARE: AFFORDABILITY

Program Purpose and Legislative Intent

The purpose of the Child Care and Development Fund (CCDF) is to help low-income working families achieve and maintain economic self-sufficiency and to improve the overall quality of

child care. The CCDF was established under PRWORA, which repealed the title IV-A child care programs and replaced them with new funding administered under the revised Child Care and Development Block Grant (CCDBG) rules and regulations.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Increase the number of children of low-income working families and families in training and education who have access to affordable child care.			
Objective: Increase access to affordable child care for low-income working families.			
4.1a. Increase the number of children served by CCDF subsidies from the 1998 baseline average (target number expressed in millions).	FY 03: Dropped FY 02: 2.2 FY 01: 2.1 FY 00: 1.92 FY 99: NA	FY 02: 12/03 FY 01: 3/03 FY 00: 1.75* FY 99: 1.65* FY 98: 1.51	Px 71 HHS 7.1
4.1b. Increase the percentage of potentially eligible children who receive CCDF subsidies from the FY 1998 baseline.	FY 03: Dropped FY 02: 14% FY 01: 12.5% [13%] FY 00: NA FY 99: NA	FY 02: 12/03 FY 01: 3/03 FY 00: 12% FY 99: 12% FY 98: 10%	Px 71 HHS 7.1
4.1c. Reduce the average percentage of family income spent in assessed child care co-payments among families receiving CCDF subsidies to the FY 1998 level and maintain at that level.	FY 03: Dropped FY 02: 5.8% FY 01: 5.8% FY 00: 5.8% FY 99: NA	FY 02: 12/03 FY 01: 3/03 FY 00: 6.1% FY 99: 6.2% FY 98: 5.8%	Px 71 HHS 7.1
4.1d. Increase the number of children receiving child care services through CCDF, TANF-direct, and SSBG funds from the 2003 baseline. (Developmental)	FY 04:	FY 04: FY 03: Baseline	Px 72 HHS 7.1
PROGRAM GOAL: Improve the availability of child care services for low-income working families.			
Objective: Increase the supply of child care available to low-income working families			
4.1e. Increase the number of slots in State-regulated child care settings from the FY 2000 baseline.	FY 03: Dropped FY 02: Developmental FY 01: NA FY 00: NA	FY 02: 12/03 FY 01: 3/03 FY 00: 3,954,046	Px 72

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
		Baseline	
4.1f. Increase the proportion of centers and homes that serve families and children receiving child care subsidies. (Developmental)	FY 04:	FY 04: FY 03: Baseline	Px 73
PROGRAM GOAL: Improve parental ability to work or attend training/education leading to greater economic self-sufficiency.			
Objective: Increase access to affordable child care for low-income families.			
4.1g. Increase the number of families working and/or pursuing training/education with support of CCDF subsidies from the FY 1998 baseline (target number expressed in millions).	FY 03: Dropped FY 02: 1.2 FY 01: 1.1 FY 00: NA	FY 02: 12/03 FY 01: 3/03 FY 00: 1.04 FY 99: 975,000 FY 98: 802,000	Px 73 HHS 6.1
4.1h. Increase the number of States that serve all low-income working families who apply without regard to their connection with TANF and without waiting lists. (Developmental)	FY 04:	FY 04: FY 03: Baseline	Px 74
* Actual number of children served in FY 99 and FY 00 revised based on improved data.			
Total Funding for Child Care Programs (dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$4816.8 FY 03: \$4816.9 FY 02: \$4841.9 FY 01: \$4588.6 FY 00: \$3550.6 FY 99: \$3185.8	Bx: budget just. Sections Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

CCDF consists of three funding streams: Mandatory, Matching, and Discretionary Funds. The Mandatory and Matching Funds are appropriated for Fiscal Years 1997 through 2002 under section 418 of the Social Security Act. A State's share of the Mandatory Funds is tied to its spending under the now-repealed AFDC-related child care programs. The Matching Funds are funds remaining after the Mandatory Funds are allocated according to the statutory formula. To receive its share of the Matching Funds, a State must provide a match at the current Medicaid rate, expend its Maintenance of Effort Funds, and obligate its Mandatory Funds. The Discretionary Fund (the Child Care and Development Block Grant fund) is appropriated annually

by Congress. Discretionary Funds are allotted to States according to a formula based on the proportion of children under five years of age, children who receive free or reduced price school lunches, and average per capita income. PWRORA provides that States may transfer up to 30 percent of their funds under the TANF program to CCDF. Transferred funds are subject to the regulations governing the Discretionary Fund. States may also spend TANF dollars directly on child care services.

States are required to spend at least four percent of their CCDF funds on activities to improve the quality and availability of child care. In addition, Congress earmarked small amounts of the Discretionary Fund to be used by States for school-age care, resource and referral services, improved quality, and expanded availability of quality infant and toddler care.

Under the statute governing CCDF, eligible children are defined as those whose parents are working, or in education or training, or who are in need of protective services. Children must be under the age of 13 years and reside with a family whose income does not exceed 85 percent of the State's median income (SMI) for that size family. States may set their own child care funding priorities for children. States may serve children 13 to 19 years of age who are under court supervision or are mentally or physically incapable of self-care. States must spend 70 percent of their CCDF monies to provide child care services for families on, or transitioning off, TANF, or at risk of welfare dependency. States are also required to give priority to children with special needs and children from very low-income families. Within the parameters of Federal statute and regulations, States have broad discretion in establishing policies and priorities that respond to State and local needs. In their biennial plans to ACF, States must provide information concerning policy issues such as family eligibility limits, sliding fee scales, provider reimbursement rates, provider health and safety requirements, and activities to improve the quality and availability of care.

Along with other parts of the PRWORA, the legislative authority for the CCDF expires on September 30, 2002. ACF anticipates continuing to promote the availability of child care services as a key element in its strategy for helping families achieve economic independence and supporting child development and success in school.

Supporting the child care needs of children and their families requires partnerships among child care providers, Head Start, public and private early childhood education, health, nutrition, mental health, and parental employment preparation programs. To this end, ACF continues to encourage collaboration at the Federal, State, and individual program levels. This involves working with ACF's partners to increase the supply of child care, to develop measures and supports for child care quality, and to provide information to help parents make sound choices about child care.

In FY 2001, States spent \$6 billion in Federal funds for child care (including significant amounts of funds transferred from TANF to CCDF) and approximately \$1.6 billion of their TANF block grant funds directly for child care services. In addition, \$2.0 billion in State funds (i.e., Matching and MOE) were spent under CCDF in FY 2001. These expenditures reflect historically high levels of Federal and State funding for child care. With these funds, many States exercised the flexibility provided under CCDF and TANF to expand the number of children served and

provide services for low-income working families without regard to their connection to TANF and without waiting lists. ACF estimates that in addition to the children served with CCDF and CCDF-related funds, approximately 700,000 additional children received child care services funded through the Social Services Block Grant and TANF dollars (Federal and State) spent directly on child care.

To improve evidenced-based policy decisions at the Federal and State levels, in Fiscal Years 2000 and 2001, the Bureau awarded 24 grants for field-initiated child care research. In addition, the Bureau has awarded twelve grants to individual doctoral students to complete dissertations on child care-related topics, and funded two research fellowships through the Society for Research in Child Development. In FY 2001 and 2002, six State CCDF Lead Agencies received grants under a new research priority entitled State Data and Research Capacity. The purpose of these grants is to improve the capacity of States to collect child care data and use the data for research purposes.

In addition, the Bureau, in partnership with the ACF Office of Planning, Research, and Evaluation, awarded a seven-year contract to work with States on a multi-site evaluation of selected child care subsidy strategies. The long-range intent of this contract is to provide reliable information to local, State, and Federal policy-makers about the efficacy of policies and programs related to child care subsidies in promoting outcomes for children and helping low-income families obtain and retain work.

Program Partnerships

Quality early childhood programs provide a crucial linkage for comprehensive, healthy child development to prepare children to be successful in school and later in life. Quality programs also provide needed supports to parents moving toward self-sufficiency through training and work. Recognizing the importance of comprehensive services, ACF encourages its State partners to create linkages between child care and health, family support, early childhood education, and other services at the State and community levels.

ACF collaborates at the Federal level with other agencies to facilitate community-level coordination. This includes coordination within ACF among the Bureau, TANF, Head Start, Office of Child Support Enforcement, Office of Refugee Resettlement, and the Administration on Developmental Disabilities. For example, the Child Care and Head Start Bureaus jointly sponsor the QUILT (Quality in Linking Together) project that helps Head Start and child care grantees as well as State pre-kindergarten programs form partnerships toward the provision of full-day, full-year early childhood services.

Within HHS, the Bureau participates with the Maternal and Child Health Bureau to sponsor the Healthy Child Care America Campaign, which aims to improve health and safety in child care by creating strong links between the child care and health communities. Externally, ACF continues to partner with the Department of Labor's Welfare-to-Work grants program, States (both individually and through national associations such as the American Public Human Services

Association and the National Governors' Association), various national child care associations, and the research community (e.g., the Bureau's Child Care Research Consortium).

In FY 2002, the Bureau placed particular emphasis on partnering with the Head Start Bureau and the Department of Education on the President's initiative, Good Start Grow Smart. This initiative, designed to ensure that child care and early childhood programs maximize the opportunity to further early learning and literacy in young children, requires States to develop voluntary guidelines for school readiness. This will involve State CCDF Lead Agencies as well as State Education Agencies. Success in this endeavor will require Federal leadership from both the ACF and the Department of Education.

PROGRAM PERFORMANCE ANALYSIS

The following are examples of some of the Bureau's activities during the first three quarters of FY 2002. CCDF grants were awarded to States, Territories, and Tribes. A kick-off event was held for the Center on the Social and Emotional Development Foundations for Early Learning. The subsidy evaluation study was initiated and States and communities that may be viable study sites have been identified. Good Start Grow Smart planning is ongoing. Finally, program announcements for the Early Learning Opportunity Act and child care research grants were published and the Bureau awarded the new discretionary grants in September 2002. (See information under Strategic Goal 2, Improve Healthy Development, Safety and Well-Being of Children and Youth.)

In the FY 2002-2003 State Plans, 44 States and Territories reported that their Lead Agency partners with the entity responsible for administering State TANF funds. At least seven States indicated that they have developed a single, "seamless" system for administering child care subsidies to all families without regard to eligibility category. Fourteen States said they have established procedures that allow families to apply for child care assistance via mail, phone, or fax, and nearly one-half of the States use the Internet to perform application functions.

Twenty States reported collaborating with the State Education Department or another public or private entity to expand services for school-age children. Thirty-seven States collaborate with their State Health Department. In an increasing number of States, collaboration involves outreach on health and safety issues to child care providers and efforts to inform low-income families about the availability of subsidized health care. In their plans, 45 States described collaboration with Head Start and 23 reported joint efforts to promote early intervention for children with developmental disabilities. Twenty-five State Lead Agencies reported active collaborations with Tribal communities to improve service delivery to dually-eligible children. Thirty-six States reported that planning and collaboration efforts are directed by State and/or local councils, committees, and advisory board that are established by the State or through legislation.

Performance Report

The number of children served through the Child Care and Development Fund increased by more than five percent from 1.65 million in FY 1999 to 1.75 million in FY 2000 (measure 4.1a). In FY

2002, it was discovered that a number of States incorrectly reported the proportion of the children included in their case-level reports that were funded through CCDF for FY 1999 and 2000. In addition, California was able to provide case-level data for FY 1999 and part of FY 2000. This allowed for more accurate California child counts than had been possible using extrapolations from expenditures data.

CCDF grantees have many efforts underway to improve access to child care for low-income families. As work continues in partnership with States to improve data collection, a number of indicators, including informal feedback from grantees, indicate that access to child care for low-income children served by CCDF is increasing.

**BUDGET TABLE LINKING FY 2002 INVESTMENTS TO
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcomes
\$12,000,000	Training & Technical Assistance	Network of contracted T & TA providers	Improved administration of CCDF and services to families and children
\$10,000,000	Policy-Related Child Care Research	Discretionary grants and contracts in support of specific research efforts	Improved information to guide policy decisions
\$1,000,000	Child Care Aware Hotline	Cooperative Agreement with National Association of Child Care Resource and Referral Agencies	Improved access to child care for parents
\$25,000,000	Early Learning Opportunities Act	Discretionary grants to local councils	Improved early learning outcomes for children

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

The Federal Child Care Information System (FCCIS) collects aggregate and case-level data from the 50 States, the District of Columbia, Puerto Rico and the Territories of American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the Virgin Islands, as required by CCDF legislation. States are responsible for compiling aggregate data at the State level and transmitting it electronically via the Internet to the FCCIS. All data received by the FCCIS are stored in a national dataset. Data standards have been set and training and technical assistance provided to all States and Territories on reporting requirements and submission procedures.

The Bureau continues to provide technical assistance (TA) designed to improve State and Tribal data submission and data quality. These TA activities include on-site visits; distribution of related documents; enhancements to the TA Tracker software; training workshops; presentations

at regional and national meetings; and software to help Tribes collect data and administer their subsidy programs.

One major TA resource, the Child Care Automation Resource Center (CCARC) is used by the States, Territories, and Tribes for interactive and immediate TA to resolve data collection problems. A unique feature of CCARC is the development of two software utilities (Child Care Data Viewer and Tribal Child Care Data Tracker), which enable States, Territories, and Tribes to use the data submitted to the Bureau for their own (local) purposes. In addition, the Bureau anticipates that its new State Data and Research Capacity Grants will support States in developing their capacity to report accurate data. While the Bureau has noted a steady improvement in data quality from the States over the last few years, it is committed to continuing its active role to facilitate States' compliance with CCDF reporting requirements.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Increase the number of children of low-income working families and families in training and education who have access to affordable child care.

Objective: Increase access to affordable child care for low-income working families.

4.1a. FY 2003: Increase the number of children served by CCDF subsidies from the 1998 baseline. (Dropped)

Performance measure 4.1a is being dropped because it excludes children served through non-CCDF Federal funding streams including SSBG and TANF-direct. As such, it underestimates the number of children receiving Federally-subsidized child care services. In addition, it is duplicative of another measure in the plan (measure 4.1d).

4.1b. FY 2003: Increase the percentage of potentially eligible children who receive CCDF subsidies from the FY 1998 baseline. (Dropped)

Data Sources: Annual Aggregate Report, ACF-800, Child Care Quarterly Case-Level Report, ACF-801.

Measure 4.1b is being dropped for FY 2003 as it underestimates the proportion of children receiving child care services with Federal and related State child care funds. It does not take into account children being served with TANF-direct, SSBG, Head Start, and State pre-kindergarten funds. It also does not take into account the variations where States set their eligibility limits or the fact that many States prioritize the lowest income families.

4.1c. FY 2003: Reduce the average percentage of family income spent in assessed child care co-payments among families receiving CCDF subsidies to the FY 1998 level and maintain at that level. (Dropped)

Data Source: Child Care Quarterly Case-Level Report, ACF-801

Measure 4.1c is being dropped for FY 2003 because it appears to encourage States to establish very low co-pays as opposed to encouraging States to implement affordable co-payment schedules that increase gradually with incomes and avoid eligibility cliffs, that require families to take increasing responsibility for the cost of care, and that maximize the number of families that can be served. At this time, ACF does not have a reliable definition of "affordable" or sufficient information about co-pays and the relationship between subsidies, co-pays, and other benefits that families receive to propose an alternative measure related to co-pays. Alternatives will be explored through research efforts and consultation with States.

Developmental Measure

4.1d. FY 2004: Increase the number of children receiving child care services through CCDF, TANF-direct, and SSBG funds from the FY 2003 baseline.

Data Source: Under Development. Child counts for CCDF will be obtained from State aggregate and case-level reports. In the absence of comparable TANF and SSBG child counts, the Bureau will use a model developed by the ASPE to estimate children served. This involves dividing yearly TANF-direct and SSBG expenditures by the CCDF average yearly cost per child to arrive at child estimates for TANF-direct and SSBG.

This new measure is designed to better assess the number of children served through a greater range of funding sources rather than CCDF only.

PROGRAM GOAL: Improve the availability of child care services for low-income working families.

Objective: Increase the supply of child care available to low-income working families.

4.1e. FY 2003: Increase the number of slots in State-regulated child care settings from the FY 2000 baseline. (Dropped)

Data Source: Under development.

This developmental measure is being dropped for FY 2003 due to data problems. The Bureau included a question related to this measure in the State Annual Aggregate Report, however, it was approved as an optional item, and only a few States responded with data. The Bureau has not identified another reliable source of national data about child care slots at this time. A new measure, 4.1f, has been added, which is thought to be a better measure of low-income family access to child care services.

Developmental Measure**4.1f. FY 2004: Increase the proportion of centers and homes that serve families and children receiving child care subsidies from the FY 2003 baseline.**

Data Source: Under Development, Child Care Quarterly Case-Level Report, ACF-801 and the Children's Foundation or, if necessary, through modifications to the State Plan Preprint and the Annual Aggregate Report (ACF-800) (Subject to OMB approval)

The numerator for this measure is the number of centers and homes that serve subsidized families and the denominator is the total number of centers and homes. In the development process, the Bureau will explore existing data sources to determine whether or not this information can be obtained without additional collection of data. If it is determined that the necessary data are not available, OMB approval will be required to add these data elements to current State reports.

Parental access to a range of child care choices is a central goal of CCDF. However, individual child care providers are not obliged to serve families receiving subsidies through CCDF. If the reimbursement rates paid by a State are too low, or if providers have difficulty getting paid or collecting overly high co-payments from families, providers may choose not to provide services to subsidized families. Therefore, the proportion of centers and homes serving subsidized families and children indicates how well the program is being administered and, ultimately, parental access to the range of choices.

PROGRAM GOAL: Improve parental ability to work or attend training/education leading to greater economic self-sufficiency.

Objective: Increase access to affordable child care for low-income working families.

4.1g. FY 2003: Increase the number of families working and/or pursuing training/education with support of CCDF subsidies from the FY 1998 baseline (target number expressed in millions). (Dropped)

Data Source: Child Care Quarterly Case Level Report, ACF 801, Item #6, Response 1, 2, or 3.

The average monthly number of children is extrapolated based on the ratio of children to families in the data. As a result, 4.1g and 4.1a (to be replaced by 4.1d) provide essentially duplicate information, therefore, this measure is being dropped for FY 2003. Data about the number of families working and/or pursuing training/education with support of CCDF subsidies will continue to be available through the Child Care Bureau.

Developmental Measure

- 4.1h. FY 2004: Increase the number of States that serve all low-income working families without regard to their connection with TANF and without waiting lists from the FY 2003 baseline.**

Data Source: Under development. Biennially, data will be obtained through the revised State Plan Preprint. In alternate years, States will be required to submit the information as an addendum to the Annual Aggregate Report, ACF-800. (Subject to OMB approval.)

This measure assesses State efforts to make policy choices that avoid perverse incentives for low-income working families who are not connected with TANF. It also measures how well States are supporting work by managing their programs without waiting lists.

STRATEGIC GOAL 2: IMPROVE HEALTHY DEVELOPMENT, SAFETY AND WELL-BEING OF CHILDREN AND YOUTH

RATIONALE

America's future – its civil society, economy and social fabric – depends upon how well the nation protects and nurtures its children. In ACF, Head Start, child care, child welfare, youth and TANF programs together provide a broad range of services that contribute to cognitive and social development, school readiness, health and safety of children and youth.

The request for an increase of \$148 million for Head Start will maintain current service levels and increase enrollment of Head Start children. The FY 2004 Head Start reauthorization proposal will provide greater flexibility to target dollars and will reallocate resources to serve a greater number of low-income children and families. The request for an increase of \$25 million will provide competitive grants to State and local organizations to mentor children of prisoners.

The President's welfare reauthorization proposal would make child well-being an explicit goal of welfare reform. Activities under this new goal would include funding demonstrations and research to promote healthy marriages and family formation. These funds will be provided to faith-based and community organizations and will fund projects of national significance focusing on public education and awareness, the use of mass media campaigns and the development of best practices, research and technical assistance.

ACF provides leadership and support for programs across the Nation that shelter runaway and homeless youth and promote positive youth development. These programs help the nation's young people to meet the challenges of adolescence and grow into adulthood.

OBJECTIVES AND MAJOR PROGRAM AREAS

5. *Promote early childhood development*

Child Care: Quality
Head Start

6. *Increase safety, permanency, and well-being of children and youth*

Child Welfare
Developmental Disabilities: Health
Youth Programs
Temporary Assistance for Needy Families: Child Well-Being

5. PROMOTE EARLY CHILDHOOD DEVELOPMENT

Approach for the Strategic Objective: Provide high quality early childhood programs, such as Head Start or accredited child care programs, so that early childhood experiences enhance children's development and school readiness.

5.1 CHILD CARE: QUALITY

Program Purpose and Legislative Intent

Since the passage of PRWORA, one quarter of one percent of the CCDF has been set-aside for technical assistance (TA). The Bureau's TA efforts have included targeted TA and support to States in systems development. The Bureau has placed particular emphasis on helping States to collect, report, and manage child care data; improve quality; and meet Federal requirements for reporting and educate consumers.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: <i>The quality of child care services and developmental outcomes for children will improve over time.</i>			
Objective: <i>Increase quality as recognized by national accreditation and certification.</i>			
5.1a. Increase by one percent (95) the number of regulated child care centers and homes nationwide accredited by a nationally recognized early childhood development professional organization from the CY 2000 baseline.	CY 04: 9,917 CY 03: 9,822 CY 02: 9,725 CY 01: 9,630 CY 00: NA	CY 04: CY 03: CY 02: 12/03 CY 01: 9237 CY 00: 9,535	Px 80 HHS 7.2
5.1b. Increase by eight percent over the previous year the number of Child Development Associate credentials awarded nationwide.	CY 03: Dropped CY 02: 150,044 CY 01: 138,125 CY 00: NA	CY 02: 12/03 CY 01: 138,930 CY 00: 127,893 CY 99: 112,130	Px 81
Objective: <i>Increase child care quality through incentives.</i>			
5.1c. Increase the number of States that encourage provider training and education through bonuses or other compensation. (Developmental)	FY 04: FY 03: NA	FY 04: FY 03: Baseline	Px 81
Objective: <i>Increase the basic health, safety and quality of child care.</i>			
5.1d. Maintain the number of States and Territories conducting unannounced inspections of regulated providers from the FY 2000 baseline.	FY 03: Dropped FY 02: 51 FY 01: NA	FY 02: 12/03 FY 01: 47 FY 00: 43	Px 82

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
		Baseline	
*N=56 (50 States, the District of Columbia, and five Territories)			

PROGRAM DESCRIPTION AND CONTEXT

In ACF's efforts to break the cycle of poverty and dependency, it is essential to focus both on parents and the next generation. Parents are more likely to succeed in employment and self-sufficiency if they have confidence in their child care arrangements. Beyond issues of health and safety, child care impacts the cognitive, emotional, and social development of children.

The Bureau works with State administrators, professional groups, service providers, and others on the following objectives: identify elements of quality and appropriate measures; inform States, professional organizations, and parents about the constituents of child care quality; influence the training and credentialing of child care workers and accreditation of child care facilities; improve linkages with health care services and Head Start; and take steps to improve the quality of child care nationally. (See also information under Strategic Goal 1, Child Care Affordability.)

The Bureau works to expand partnerships with States and among early childhood programs to improve quality in early care and education. With their infant and toddler earmarks, States are recruiting additional caregivers; providing health outreach, including training and consultation; offering incentives for provider accreditation and training; and sponsoring specialized training for infant and toddler caregivers. A number of States have implemented initiatives to improve the supply and quality of infant and toddler care—some through partnerships with Early Head Start.

With CCDF monies, including funds earmarked for school-age care and resource and referral, States reported efforts to improve both the supply and quality of school-age care. These efforts include incentives for providers seeking accreditation, specialized curriculum development, grants to programs seeking to improve the quality of their services, and development of specialized licensing standards for school-age programs. In many States, efforts to improve the quality and supply of school-age care target low-income neighborhoods, and non-English speaking populations.

In addition to the earmarks, States are required to spend at least four percent of CCDF funds to improve the quality and availability of child care and offer additional services to parents, such as resource and referral counseling on selecting appropriate child care providers.

In FY 2001, the Bureau awarded \$2.5 million in discretionary grant funds appropriated to ACF for Technical Assistance to Improve Child Care Facilities. (Funds for this purpose were not appropriated in FY 2002.) Nine grantees around the country are providing technical assistance to

child care providers to improve the quality and supply of child care facilities, including child care for infants and toddlers and children with disabilities. A cooperative agreement was awarded to a university and its consortium of universities and early childhood organizations for the Center on the Social and Emotional Foundations for Early Learning. The purpose of this five-year project is to support the development of a national center to assist Head Start and child care programs to identify and implement practices that demonstrate effectiveness in promoting children's social and emotional competence. In FY 2001, the Child Care Bureau also awarded 26 new discretionary grants to local councils under the Early Learning Opportunities Act (ELOA). Another group of 31 ELOA grants was awarded in FY 2002. The Bureau is working with the FY 2001 and 2002 ELOA grantees to advance early learning and literacy and to assist them in evaluating the outcomes of their efforts.

As described under Strategic Goal 1, the Bureau provides technical assistance and support to grantees in implementing CCDF. Directly, and through its technical assistance contractors, the Bureau informs States about successful programs and models; offers on-site consultation; facilitates exchanges among peers; and sponsors meetings, conference calls, and conferences designed to provide training and peer linkages. In partnership with the HHS Maternal and Child Health Bureau, the Bureau sponsors the Healthy Child Care America campaign to develop and strengthen linkages between child care providers, health professionals, and families, and ultimately to improve the health and safety of children in child care settings.

Program Partnerships

One key strategy for improving the quality of care, as well as its affordability and availability, is to create linkages between CCDF, early childhood programs and other agencies that provide crucial services to children and families. The Bureau has actively promoted collaboration through policy and technical assistance. In their biennial CCDF Plans, States are required to discuss both the coordination and collaboration that occurred in developing their plans and the results of that collaboration. The Bureau will monitor State progress toward the goal of collaboration through the State reports. As indicated in section 4.1, States submitted new plans on July 1, 2001, for the two-year period beginning October 1, 2001.

In addition, the Bureau coordinates with partners in ACF, HHS, and other departments to address barriers impeding States' efforts to provide quality services to children and families. This coordination includes encouraging grantees to provide high quality, full-day, full-year early childhood services by linking CCDF with Head Start and State pre-kindergarten programs. The HHS health agencies that assist with attaining health targets include the Maternal and Child Health Bureau, Community Health Centers, the Substance Abuse and Mental Health Services Administration, the Centers for Medicare and Medicaid Services, and their constituencies. The Bureau works with the Federal Interagency Coordinating Council (FICC) and others to ensure that children with special needs who are eligible for CCDF services also receive assessments and early intervention services. In 2002, the FICC and the Bureau co-sponsored two policy forums on child care and children with disabilities.

PROGRAM PERFORMANCE ANALYSIS

States continue to expand their innovative uses of CCDF quality improvement funds to assure more children are cared for in environments that support their developmental needs. In their FY 2002-2003 CCDF State Plans, States reported that they are using quality funds to educate parents about making good child care choices; to provide grants and loans to expand the number and quality of child care slots; to increase child care provider wages, benefits, and training; and to monitor the safety and quality of care.

The trend continues toward States implementing systems of tiered reimbursement whereby providers are paid more if they can demonstrate that they offer higher quality care. In their Plans, 29 States indicated that they provide rate differentials for various levels of quality. Most States indicated they are working toward a system of professional development for child care providers and workers. Nearly a dozen States have implemented the North Carolina TEACH model combining professional development and training with salary enhancements. State-funded pre-kindergarten programs now exist in 42 States and nearly all States reported efforts to link child care, Head Start, and pre-kindergarten programs more closely together.

Performance Report

The data needed for reporting performance on two of the current measures related to child care quality, i.e., accreditation of facilities (measure 5.1a) and the Child Development Associate (measure 5.1b) are furnished by independent national bodies. These organizations are credible sources of information about provider accreditation and certification. The Bureau established the baseline for measure 5.1a with CY 2000 data from the National Association for Family Child Care, the National Association for the Education of Young Children (NAEYC), and the National School-Age Care Alliance. Based on their combined data, there were 9,237 accredited child care facilities nationwide in CY 2001. It is unclear whether the changes in the NAEYC accreditation system resulted in the decrease in accredited facilities between CY 2000 and 2001. 5.1a measures the number of accredited facilities in relationship to the number of regulated child care centers and homes, as reported by the organizations listed above and the Children's Foundation. (*The 2001 Child Care Center Licensing Study*).

The NAEYC, one of several accrediting organizations reported 6,830 NAEYC-accredited child care facilities in 1999 and 8,332 in 2000. According to the National School-Age Care Alliance (NSACA), 211 of its member child care facilities were accredited in 2000. Therefore, of an estimated 106,246 regulated child care centers, 8,543 were accredited in 2000 through NAEYC and NSACA. In addition, 992 of the 290,667 regulated family and group child care homes reported by the Children's Foundation were accredited through the National Association for Family Child Care in 2000.

The NAEYC is revising its accreditation system. The new system will be announced in November 2002 and is scheduled to be operational in 2005. The effects of this new system on measure 5.1a cannot be determined at this time. However, the impact could be substantial

because NAEYC accredits a larger proportion of child care facilities annually than do the two other accrediting organizations that are sources of data for measure 5.1a.

Providing an accurate count of the total number of child care workers is also difficult. No reliable estimate of the number of such workers exists. The ability to provide the total number of workers is hampered by several factors; e.g., no common definition exists for the term "child care worker." The Bureau of Labor Statistics' National Industry-Occupation Employment Matrix includes at least three employee categories applicable to child care workers and omits some obvious providers such as the self-employed. In FY 2002, the Child Care Bureau funded two grants designed to increase knowledge about child care providers and staff.

The Council for Early Childhood Professional Recognition awards Child Development Associate (CDA) credentials to individual child care workers (measure 5.1b). In calendar year (CY) 2000, the Academy reported 127,893 individuals with CDA credentials and 138,930 in CY 2001, an increase of 11,037 or 8.6 percent.

Data Issues

As discussed in Strategic Goal 1, the Bureau has worked with States and Territories for several years to develop appropriate and achievable program goals and measures. The goals and measures in this document reflect the consensus-building and participatory process.

Some of these child care quality performance measures require new reporting and/or data gathering methods, including obtaining information from national organizations. The Bureau intends to address these data issues in several ways. Information relevant to measures already included in State Plans will be used to help tell the performance story. The State Plan Preprint submitted biennially by States has been, or will be, amended to include additional items related to the Bureau's performance measures.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: The quality of child care services and developmental outcomes for children will improve over time.

Objective: Increase quality as recognized by national accreditation and certification.

5.1a. FY 2003: *Increase by an additional one percent the number of regulated child care centers and homes nationwide accredited by nationally recognized early childhood development professional organizations and accrediting entities from the CY 2000 baseline.*

FY 2004: *Increase by an additional one percent the number of regulated child care centers and homes nationwide accredited by nationally recognized early*

childhood development professional organizations and accrediting entities from the CY 2000 baseline.

Data Source: National Association for Family Child Care, the National Association for the Education of Young Children, and the National School-Age Care Alliance.

The above performance goal is an indicator of quality improvement. Accreditation of child care facilities has been linked to better outcomes for children and is increasingly accepted as a marker of good quality care. Several States use CCDF quality improvement funds in various ways to support accreditation for child care centers and homes.

Through intense efforts with program stakeholders to explore alternative ways to measure progress toward improving the quality of child care services, the goals in this section have been developed to address child health, safety, and development. This is done through inspection and monitoring of child care facilities, as well as incentives for program accreditation and staff training.

5.1b. FY 2003: Increase by eight percent over the previous year the number of Child Development Associate credentials awarded nationwide. (Dropped)

Given that the CDA is only one approach to provider education and training, the Bureau is dropping this measure in FY 2003 in favor of 5.1c, which recognizes both training and compensation issues for providers.

Objective: Increase child care quality through incentives.

5.1c. FY 2004: Increase the number of States that encourage provider training and education through bonuses or other compensation from the FY 2003 baseline. (Developmental)

Data Source. Biennially, data could be obtained by revising the State Plan Preprint. In alternate years, States could be required to submit the information as an addendum to the Annual Aggregate Report, ACF-800. (Subject to OMB approval.)

This new measure assesses State efforts to encourage or require increased provider training. Given the association that exists in research between provider training/compensation, child care quality, and outcomes for children, this measure serves as a proxy for quality and outcomes for children. Longer-term, in connection with reauthorization of the CCDF and Good Start Grow Smart, the Bureau will consult with States and others about a more direct approach to assessing child outcomes, which could include a measure based on State assessment of school readiness at kindergarten entry.

Objective: Increase the basic health, safety and quality of child care.

5.1d. FY 2003: Increase the number of States and Territories conducting unannounced inspections of regulated providers from the FY 2000 baseline. (Dropped)

Measure 5.1d is being dropped because research suggests that conducting unannounced visits indiscriminately on all providers is probably not the best use of limited State resources. Unannounced visits appear to be most useful with providers who have a history of low compliance with regulations.

5.2 HEAD START

Program Purpose and Legislative Intent

The purpose of Head Start is to provide comprehensive child development services to children and families. This is achieved through grants to local public and private non-profit and for-profit agencies. Head Start is authorized under Section 639 of the Head Start Act, as amended. Intended primarily for preschoolers from low-income families, Head Start promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services. Head Start programs emphasize cognitive, language and socio-emotional development to enable each child to develop and function at his or her highest potential. Head Start engages parents in their children's learning and helps them in making progress toward their educational, literacy and employment goals.

In FY 1995, the Early Head Start program was established in recognition of mounting evidence that the earliest years, from birth to three years of age, matter a great deal to children's growth and development. It is estimated that during FY 2004, 62,400 children will be enrolled in Early Head Start programs.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Enhance Children's Growth and Development.			
Objectives: (1) Children demonstrate improved emergent literacy, numeracy and language skills, and (2) Children demonstrate improved general cognitive skills.			
5.2a. Achieve at least an average 34 percent gain (12 scale points) in word knowledge for children completing the Head Start program.	FY 04: 34% FY 03: 32% FY 02: 32% FY 01: 10 FY 00: NA	FY 04: FY 03: 10 (32%) FY 01: 10 (32%) FY 00: 10 (32%)	Px 92 HHS 7.2
5.2b. Achieve at least an average 52	FY 04: 52% FY 03: 43%	FY 04: FY 03:	Px 92

percent gain (4 scale points) in mathematical skills for children completing the Head Start program.	FY 02: 43% FY 01: 3 FY 00: NA	FY 02: 3 (43%) FY 01: 3 (43%) FY 00: 3 (43%)	HHS 7.2
5.2c. Achieve at least an average 70 percent gain (3.4 scale points) in letter identification for children completing the Head Start program.	FY 04: 70% FY 03: 70% FY 02: 70% FY 01: 3.4 FY 00: NA	FY 04: FY 03: FY 02: 2 (38%) FY 01: 2 (38%) FY 00: 1.5 (35%)	Px 92 HHS 7.2
Objective: (3) Children demonstrate improved gross and fine motor skills.			
5.2d. Achieve at least an average 43 percent gain (1.24 scale points) in fine motor skills for children completing the Head Start program.	FY 04: 43% FY 03: 43% FY 02: 43% FY 01: 1.24 FY 00: NA	FY 04: FY 03: FY 02: 1.05 (34%) FY 01: 1.05 (34%) FY 00: 1.05 (34%)	Px 92 HHS 7.2
Objectives: (4) Children demonstrate improved positive attitudes toward learning. (5) Children demonstrate improved social behavior and emotional well-being.			
5.2e. Achieve at least an average 14 percent gain (2 scale points) in social skills for children completing the Head Start program.	FY 04: 14% FY 03: 10% FY 02: 10% FY 01: 1.4 FY 00: NA	FY 04: FY 03: FY 02: 1.9 (13%) FY 01: 1.9 (13%) FY 00: 1.4 (10%)	Px 92 HHS 7.2
Objective: (6) Children demonstrate improved physical health.			
5.2f. Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.	FY 04: 80% FY 03: 80% FY 02: 80% FY 01: 80% FY 00: NA	FY 04: FY 03: FY 02: 79% FY 01: 79% FY 00: 77%	Px 92
PROGRAM GOAL: Strengthen Families			
Objective: (1) Head Start parents demonstrate improved parenting skills.			
5.2g. Achieve goal of at least 70 percent the percentage of parents who report reading to child three times per week or more.	FY 04: 70% FY 03: 70% FY 02: 70% FY 01: 70% FY 00: NA	FY 04: FY 03: FY 02: 69% FY 01: 69% FY 00: 66%	Px 93 HHS 7.2
Objectives: (2) Parents improve their self-concept and emotional well-being. (3) Parents make progress toward their educational, literacy and employment goals.			
5.2h. Maintain the percentage of Head Start employees who are parents of Head Start children.	FY 04: 30% FY 03: 30% FY 02: 30% FY 01: 30% FY 00: 30%	FY 04: FY 03: FY 02: 28% FY 01: 29% FY 00: 30.9%	Px 93

	FY 99: 30%	FY 99: 30.6% FY 98: 29%	
Head Start employed approximately 193,350 staff members. Of these 54,600 are parents of Head Start children.			
PROGRAM GOAL: Children receive educational services.			
Objective: (1) Programs provide developmentally appropriate educational environments.			
5.2i. Increase the percentage of classroom teachers with a degree in early childhood education (ECE), a child development associate credential, a State-awarded preschool certificate, a degree in a field related to ECE plus a State-awarded certificate or who are in CDA training and have been given a 180-day waiver, consistent with the provisions of Section 648A(a)(1) of the Head Start Act.	FY 04: 100% FY 03: 100% FY 02: 100% FY 01: 100% FY 00: 100% FY 99: 100%	FY 04: FY 03: FY 02: 90% FY 01: 86% FY 00: 94% FY 99: 93% FY 98: 95%	Px 93 HHS 7.2
5.2j. Increase the percentage of teachers with AA, BA, Advanced Degree or a degree in a field related to early childhood education	FY 04: 50% FY 03: 50% FY 02: 47%	FY 04: FY 03: FY 02: 51% FY 01: 45% FY 00: 41% FY 99: 37% FY 98: 32% FY 97: 33%	Px 93 HHS 7.2
24,797 Head Start teachers have an Associate Degree or better. An additional 10,565 teachers are enrolled in degree programs.			
Objective: (2) Staff interact with children in a skilled and sensitive manner.			
5.2k. Maintain the average lead teacher score on an observational measure of teacher-child interaction.	FY 04: 73 FY 03: 73 FY 02: 73 FY 01: 73 FY 00: NA	FY 04: FY 03: FY 02: 72 FY 01: 72 FY 00: 73	Px 94 HHS 7.2
PROGRAM GOAL: Children in Head Start receive health and nutritional services.*			
Objective: Children in Head Start receive needed medical, dental and mental health services.			
5.2l. Increase the percentage of Head Start children who receive necessary medical treatment after being identified as needing medical treatment.	FY 04: 97% FY 03: 97% FY 02: 94% FY 01: 92% FY 00: 90% FY 99: 88%	FY 04: FY 03: FY 02: 89% FY 01: 88% FY 00: 88% FY 99: 87% FY 98: 88%	Px 94 HHS 3.2
807,959 children were up-to-date on a schedule of age appropriate preventive and primary health care. 171,190 children received medical treatment as a result of a diagnosed health condition.			
5.2m. Maintain the percentage of Head Start children who receive	FY 04: 95% FY 03: 95%	FY 04: FY 03:	Px 94

necessary dental treatment after being identified as needing dental treatment.	FY 02: 90% FY 01: 90% FY 00: 90% FY 99: 96%	FY 02: 76% FY 01: 77% FY 00: 78% FY 99: 81% FY 98: 83%	HHS 3.2
157,191 children received or are receiving dental treatment as a result of an examination and diagnosis.			
5.2n. Increase the percentage of Head Start children who receive necessary treatment for emotional or behavioral problems after being identified as needing such treatment.	FY 04: 90% FY 03: 90% FY 02: 85% FY 01: 83% FY 00: 81% FY 99: 81%	FY 04: FY 03: FY 02: 74% FY 01: 77% FY 00: 77% FY 99: 75% FY 98: 75%	Px 94 HHS 3.5
Of the children referred for mental health services outside the Head Start program, 15,544 received treatment.			
NEW EVALUATION MEASURES			
5.2o. Percentage of all Head Start grantees that are reporting child outcome data using the National Reporting System. (Developmental)	FY 04: NA	FY 04: Baseline	Px 95
5.2p. Proportion of Head Start grantees, using the National Reporting System, that meet or exceed numerical targets in selected dimensions of school readiness. (Developmental)	FY 04: NA	FY 04: Baseline	Px 95 HHS 7.2
Total Funding for All Head Start Programs (dollars in millions)	FY 04: \$6815.6 FY 03: \$6667.5 FY 02: \$6537.0 FY 01: \$6199.8 FY 00: \$3866.2 FY 99: \$4658.1		
See detailed Budget Linkage Table in Part I for line items included in funding totals.			

PROGRAM DESCRIPTION AND CONTEXT

In 2002, more than 912,000 children were enrolled in Head Start programs. These programs operated 18,500 centers with 49,800 classrooms. Of the children served, 34.5 percent are African-American; 30.4 percent are White; 28.7 percent are Hispanic; 3.3 percent are American Indian; and 2.0 percent are Asian.

Sixty-four percent of all Head Start programs enrolled children from more than one dominant language and 20 percent enrolled children from four or more dominant language groups. Head Start programs endeavor to meet the needs of diverse communities and cultures in America. Head Start enrolls and serves children in a myriad of settings, primarily community-based organizations operating north and south from Florida to Alaska, and east to west from Puerto

Rico to Micronesia through a network of 1,565 largely community based program grantees. In FY 2004, Head Start is projecting that it will increase enrollment levels to 923,000 children.

More than 244,000 Head Start children speak a language other than English. Besides staffing Head Start centers with staff speaking the same language as the children enrolled, Head Start provides special programs for special populations. In FY 2002, Head Start served more than 121,000 children with disabilities, 12 percent of the total enrollment. Disabilities included visual, hearing, speech, and health impairments, mental retardation, serious emotional disturbances, specific learning disabilities, and developmental delays.

The basic philosophy guiding the Head Start program is that children benefit from quality early childhood experiences and that effective intervention can be accomplished through high quality comprehensive services for children. Head Start supports families by providing direct and referral services when needed and fosters community involvement, especially in providing health and social services for enrolled children and their families. Almost 30 percent of Head Start program employees are parents of Head Start children.

Head Start continues to emphasize its role as a national laboratory to test and refine educational approaches, and to use child outcomes to help guide program development. Recognition of emerging research, changing needs and developing trends enable the Head Start Bureau to make resources available for targeted programmatic improvements. Head Start conducts research, demonstration, and evaluation activities to test innovative program models and to assess program effectiveness. During the first nine months of FY 2002 Head Start selected and allocated funds to successful competing applicants who will enrolled 6,742 additional children in the Early Head Start programs. This is a key area of focus as research demonstrates the critical significance of very early childhood as a time for laying the foundations necessary for optimal future development.

In response to the legislative mandate, substantial resources were allocated during the first nine months of FY 2002 to upgrade the credentials of Head Start classroom teachers. More than \$80 million in annual funding was earmarked to pay for teacher training and to continue to increase staff compensation. Grantees were required to develop plans for using their allocation to increase the numbers of teachers with degrees, a factor which research indicates is strongly associated with positive child outcomes. Additionally, significant resource allocations have been targeted to train thousands of Head Start teachers in effective methods for implementing literacy curricula in Head Start programs across the country (see performance measures 5.2a and 5.2c). This activity, *Project Step*, conducted in concert with a Presidential initiative, began in FY 2002.

Project Step is not a curriculum; it is a professional training program to enhance the work going on in Head Start programs. *Project STEP* provides nationwide research-based literacy training to all Head Start programs, builds on existing quality improvement and professional development efforts; and creates a consistent foundation of staff knowledge and skills in early literacy to enhance the locally designated curriculum and staff development efforts. During four-day training conferences, teachers receive 32 hours of research-based training to support grantee-designated Early Literacy Specialists. Their training includes instruction on approaches to teaching strategies, optimum classroom arrangements, and the use and placement of materials to

promote children's literacy and language learning. Ultimately, more than 50,000 Head Start staff will be trained and there will be a literacy-enriched environment in all programs.

Health: Head Start emphasizes the importance of the early identification of health problems. Every child is in a comprehensive health program that includes immunizations, medical, dental, and mental health, and nutritional services. Basic to the philosophy of the Head Start program is that healthy children will be better able to learn. Head Start made funds available to programs to assist in meeting the costs of critical dental treatment for children in communities where Medicaid-funded dental services are difficult or impossible to access (see performance measure 5.2m). This will result in more Head Start children receiving needed dental treatment. Research shows that for optimal learning to occur, children's physical health and well-being are essential.

Head Start Program Monitoring: Head Start's legislation requires a team led by a Federal representative to examine Head Start program performance standard compliance at least every three years for each program. ACF regional office and central office staff conduct more than 500 on-site reviews each year.

Other Information and Management Systems: All local programs receiving Head Start funds are required to submit an annual Program Information Report tracking program participation statistics such as the age of children, the kind of education program they receive, and the medical, dental and mental health services the children receive. Annual one-time questions capture information about children's families and the kind of support services required such as job training, education, housing, counseling and other community based services. Head Start's new application includes a component which tracks costs hourly, daily and annually across service components and allows judgments to be made by Federal officials about the reasonableness of a Head Start grantee's proposed costs.

Head Start Training & Technical Assistance Network and Quality Improvement Centers: Head Start makes a substantial annual investment to support regional and sub-regional Head Start quality improvement centers. The national Early Head Start Resource Center for leadership and support provides training and technical assistance for programs enrolling infant, toddlers and pregnant women. All training and technical assistance services foster collaboration between community agencies, governments, academic institutions and Head Start programs. Head Start sets aside funds for training and technical assistance to help local projects meet the Head Start program performance standards and maintain and improve the quality of local programs, emphasizing early literacy and school readiness and improved credentials for classroom teachers.

Program Partnerships

The Administration for Children and Families and the Head Start Bureau work closely with several agencies within HHS, the Department of Education and other agencies and institutions of higher learning in support of efforts to maintain and improve the quality and scope of Head Start program services.

- Health Resources and Services Administration: The Head Start Bureau signed an inter-agency agreement to support the provision of technical expertise in the area of oral health to both the Head Start Bureau and Regional Offices.
- Public Health Service, Maternal and Child Health Bureau: Inter-agency agreement to fund activities of the National Early Hearing Detection and Intervention Technical Assistance Centers to provide expertise in hearing screening, diagnosis and intervention services to infants, toddlers and young children.
- Department of Education and National Institutes of Health: Early Head Start Fathers Study to help develop strategies to involve fathers in aspects of the Early Head Start program.
- Department of Education: Collaboration on Early Childhood Longitudinal Study, kindergarten and birth cohorts, to increase knowledge about predictors of school readiness.
- National Institute of Child Health and Human Development, Department of Education and the National Institute of Mental Health: Inter-agency collaboration on research initiative to identify child development interventions to promote school readiness.
- America Reads and the Department of Education: to develop and implement literacy curricula in early childhood settings.
- Partnership with Office of Child Support Enforcement: to foster collaboration between Head Start and OCSE agencies in furthering the support of children.
- National Center on Family Literacy: to assist Head Start in developing literacy curricula.
- Historically Black Colleges and Universities, Hispanic Serving Institutions of Higher Learning, and Indian Controlled Land Grant Colleges and Universities: to develop faculty support for curricula in early childhood development for training of teachers.

PROGRAM PERFORMANCE ANALYSIS

Head Start sets goals and measures program outcomes for children related to children's health, emergent literacy, numeracy and language skills, cognitive skills, gross and fine motor skills, attitudes towards learning, social behavior, and emotional well-being (selected indicators are reported below). Other reported indicators include parental involvement in educational activities, professional development of teaching staff, observed classroom quality, and provision of needed physical, dental, and mental health services.

During the Head Start experience, children improve the cognitive and social skills that indicate readiness to learn more in kindergarten. Head Start's Family and Child Experiences Survey (FACES) uses measures of child performance for which national norms are available, such as the Peabody Picture Vocabulary Test -- III and subtests of the Woodcock-Johnson Psychoeducational Battery-Revised. Note that national mean scores are the average scores achieved by children at all levels of income. Head Start works to narrow the gap between disadvantaged children and all children in school readiness skills during the program year.

None of Head Start's 48,000 classrooms scored below a minimal level of quality, unlike many other pre-school and child care settings. Head Start classroom quality is linked to child outcomes. For example, children score higher on early literacy measures when they experience richer teacher-child interaction, more language learning opportunities, and a classroom well equipped with learning resources. This outcome, among others, is a proxy measure of the

effectiveness of Head Start's national training and technical assistance network in which substantial funds are invested.

Performance Report

For the program goal "Enhance children's growth and development", the targets have been set to be both educationally meaningful and realistically achievable. Head Start's Family and Child Experiences Survey (FACES), a longitudinal study, is showing encouraging results. The most current data (2002) indicate that Head Start children completing the program are achieving an average 32 percent gain in word knowledge (measure 5.2a) compared to average gain among all children during the pre-K year of 19 percent. In addition, Head Start children are achieving an average 43 percent gain in mathematical skills (measure 5.2b) compared to the average gain for all pre-K children of 30 percent. Considering most Head Start children enter the program with scores below national norms on most measures of school readiness, these early indications of program performance are quite impressive.

However, in other areas, such as letter identification (measure 5.2c), increased programmatic attention will be required. The target represents an aggressive goal relative to previous performance. This increased attention is addressed through multiple approaches at the program level, including new initiatives in family literacy, teacher credentialing, a new emphasis on local program use of child outcome data in self-evaluations, and a major teacher training initiative focused on developing literacy-rich classrooms.

FACES also showed encouraging results on program quality. Head Start classroom quality is good on average, with approximately 75 percent of over 500 observed classrooms rating good quality or higher on the Early Childhood Environment Rating Scale.

Head Start continues to employ and provide training to 55,900 parents of Head Start children (measure 5.2h); 28 percent of present Head Start employees are parents of Head Start children. Head Start parents achieve required credentials thereby benefiting from career training, and enjoy long term stable employment in Head Start. These parents, many of whom were participants in temporary public assistance, participate in employer provided health care and retirement benefits accruing benefits not only for themselves, but also for their children.

The target established in the Head Start Act for qualified teaching staff (measure 5.2i) was 100 percent; the actual was 90 percent. This shortfall may be due to a combination of staff turnover and/or limited access to training and credentialing opportunities in certain areas of the country. In partnership with institutions of higher education, Head Start is working to ensure that a majority of teachers obtain associate's or bachelor's degrees in early childhood education over the next few years.

The Head Start program has maintained a high level of effort in accomplishing a nearly 100 percent rate for child immunizations and rates approaching 90 percent for health examinations. While performance has remained somewhat stable for measures 5.2m-n with a slight increase in 5.2l; all three Head Start health indicators (measures 5.2l-n) are below the projected target levels. However, the number of children identified as needing treatment has increased for all three

measures. The Head Start Bureau is committed to improving performance for these three measures for FY 2004 because health plays such a critical role in the overall positive development of children.

Head Start has been selected as a pilot for linking resources, outputs, and outcomes, as a way of using performance information to improve program effectiveness. This pilot will help to lay the groundwork for informing management decisions for resource allocation, improving internal management, and providing greater accountability through more integrated financial and performance reporting. The table below illustrates the use of selected resources to support child progress.

**BUDGET TABLE LINKING INVESTMENTS TO
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcome
\$49,293,000	Training & Technical Assistance	Training, mentoring and coaching in implementing early childhood curriculum, with major focus on early literacy and numeracy activities. Collaboration with Department of Education Early Reading First for literacy and training materials.	Children ready to learn. Successful transition to kindergarten
\$3,000,000	Implement Family Literacy Activities	Revamped literacy-enriched training and technical assistance provided by the National Center on Family Literacy. Research based training and materials.	Increased capacity of families to support children's development and learning.
\$6,663,416	Implement plan for training and credentialing of Head Start teachers (Note: Program Description and Context Project Step)	Formal college course work leading to Associate's and Bachelor's degrees in Early Childhood Education via partnerships with Institutions of Higher Education.	Increased number of college degreed teachers. Developmentally appropriate learning environments and activities. Supportive adult-child interactions.
\$1,100,000	Implement dental health and social-emotional grants/contracts	Training and Technical Assistance for Regional Office staff and Head Start programs.	Increased capacity of Head Start staff to address children's health needs. Improved oral health and social-emotional outcomes for

		children.
--	--	-----------

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

The Family and Child Experiences Survey (FACES) is a longitudinal study of a nationally representative sample of 3,200 children and families in 40 Head Start programs which provides data for the Head Start child outcomes measures. OMB granted approval in July 1997, following a field test of 2,400 children in the spring of 1997. Full implementation began in the fall of 1997 and includes assessment of the same children before and after their Head Start experience (whether one or two years), as well as in the spring of kindergarten and the spring of first grade. Data sources include parent interviews, staff interviews, teacher questionnaires, classroom observations, and direct child assessments. FACES, designed as a periodic, longitudinal data collection activity, provided the baseline data for 1999.

Because of the need to collect longitudinal data, (including pre- and post-test and follow-up data on child performance to assess progress), it is not feasible to provide FACES data on an annual basis. However, regular, periodic data collection for additional program quality and outcome measures provided by the Head Start Program Information Report will ensure a regular, national picture of program quality. The 2001-2002 cohort of FACES included a new nationally representative sample of 43 programs. Data collection began in fall 2000, following children and families for one or two years of program attendance, with a kindergarten follow-up. Targets established for FY 2003-2004 were based on this cohort. Current plans project a third three-year cycle of FACES data collection for FY 2003-2004.

Head Start's Program Information Report provides on-time verified data that are collected annually from all Head Start programs using an OMB-approved data collection instrument. This instrument is revised periodically to capture information that is relevant to reporting on program objectives. The data yields are used for several performance measures reported in the summary tables in this plan. This data collection is automated to improve the efficiency in the collection and analysis of data. Head Start achieves a 100 percent response rate annually from 2500 respondents.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Enhance children's growth and development.

Objectives: Children demonstrate improved emergent literacy, numeracy and language skills.
Children demonstrate improved general cognitive skills.

- 5.2a.** *FY 2003: Achieve at least an average 32 percent gain (10 scale points) in word knowledge for children completing the Head Start program. (The average gain among all children during the pre-K year is 19 percent.)*

FY 2004: Achieve at least an average 34 percent gain (12 scale points) in word knowledge for children completing the Head Start program. (The average gain among all children during the pre-K year is 19 percent.)

- 5.2b.** *FY 2003: Achieve at least an average 43 percent gain (3 scale points) in mathematical skills for children completing the Head Start program. (The average gain among all children during the pre-K year is 30 percent.)*

FY 2004: Achieve at least an average 52 percent gain (4 scale points) in mathematical skills for children completing the Head Start program. (The average gain among all children during the pre-K year is 30 percent.)

- 5.2c.** *FY 2003: Achieve at least an average 70 percent gain (3.4 scale points) in letter identification for children completing the Head Start program. (The average gain among all children during the pre-K year is 50 percent.)*

FY 2004: Achieve at least an average 70 percent gain (3.4 scale points) in letter identification for children completing the Head Start program. (The average gain among all children during the pre-K year is 50 percent.)

Objective: Children demonstrate improved gross and fine motor skills.

- 5.2d.** *FY 2003: Achieve at least an average 43 percent gain (1.24 scale points) in fine motor skills for children completing the Head Start program.*

FY2004: Achieve at least an average 43 percent gain (1.24 scale points) in fine motor skills for children completing the Head Start program.

Objectives: Children demonstrate improved positive attitudes toward learning.
Children demonstrate improved social behavior and emotional well-being.

- 5.2e.** *FY 2003: Achieve at least an average 10 percent gain (1.4 scale points) in social skills for children completing the Head Start program.*

FY 2004: Achieve at least an average of 14 percent gain (2 scale points) in social skills for children completing Head Start program.

Objective: Children demonstrate improved physical health.

- 5.2f.** *FY 2003: Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.*

FY 2004: *Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.*

Objective: Head Start parents demonstrate improved parenting skills.

- 5.2g.** **FY 2003:** *Maintain the increase from the baseline year at 70 percent the percentage of parents who read to child three times per week or more.*

FY 2004: *Achieve goal of at least 70 percent of parents who read to child three times per week or more.*

Objectives: Parents improve their self-concept and emotional well-being.
Parents make progress toward their educational, literacy and employment goals.

- 5.2h.** **FY 2003:** *Maintain at 30 percent the percentage of Head Start employees who are parents of Head Start children.*

FY2004: *Maintain at 30 percent the percentage of Head Start employees who are parents of Head Start children.*

Data Sources: Head Start Program Information Report.

PROGRAM GOAL: Children receive educational services.

Objective: Programs provide developmentally appropriate educational environments.

- 5.2i.** **FY 2003:** *Achieve the goal of 100 percent of classroom teachers with a degree in early childhood education (ECE), a child development associate credential, a State-awarded preschool certificate, a degree in a field related to ECE plus a State-awarded certificate, or who are in CDA training and have been given a 180 day waiver, consistent with the provisions of Section 648A(a)(2) of the Head Start Act.*

FY 2004: *Maintain at 100 percent of classroom teachers with a degree in early childhood education (ECE), a child development associate credential, a State-awarded preschool certificate, a degree in a field related to ECE plus a State-awarded certificate, or who are in CDA training and have been given a 180 day waiver, consistent with the provisions of Section 648A(a)(2) of the Head Start Act.*

- 5.2j.** **FY 2003:** *Increase the percentage of teachers with an AA, BA, Advanced Degree or a degree in a field related to early childhood education.*

FY 2004: *Increase the percentage of teachers with an AA, BA, Advanced Degree or a degree in a field related to early childhood education.*

Objective: Staff interact with children in a skilled and sensitive manner.

5.2k. *FY 2003: Maintain at the FY 1999 baseline of 73 points the average lead teacher score on an observational measure of teacher-child interaction.*

FY 2004: Maintain at the FY 1999 baseline of 73 points the average lead teacher score on an observational measure of teacher-child interaction.

Data Sources: Family and Child Experiences Survey (FACES) observation of classroom teachers

PROGRAM GOAL: Children in Head Start receive health and nutritional services.

Objective: Children in Head Start receive needed medical, dental and mental health services.

(Note: Beginning with the FY 2004 plan, ACF has integrated its Head Start measures into a single strategic objective area. Measures 5.2l-n were formerly 6.1a-c.)

5.2l. *FY 2003: Increase from 88 percent in FY 1998 to 97 percent the percentage of Head Start children who receive necessary medical treatment after being identified as needing medical treatment.*

FY 2004: Increase from 88 percent in FY 1998 to 97 percent the percentage of Head Start children who receive necessary medical treatment after being identified as needing medical treatment.

5.2m. *FY 2003: Increase to 95 percent the percentage of Head Start children who receive necessary dental treatment after being identified as needing dental treatment.*

FY 2004: Increase to 95 percent the percentage of Head Start children who receive necessary dental treatment after being identified as needing dental treatment.

5.2n. *FY 2003: Increase from 75 percent in FY 1998 to 90 percent the percentage of Head Start children who receive necessary treatment for emotional or behavioral problems after being identified as needing such treatment.*

FY 2004: Increase from 75 percent in FY 1998 to 90 percent the percentage of Head Start children who receive necessary treatment for emotional or behavioral problems after being identified as needing such treatment.

National Reporting System

“President Bush has directed HHS to develop a strategy to ensure that, for the first time, every Head Start center assesses the standards of learning in early literacy, language, and

numeracy skills. This new accountability system will be field tested in the 2002-2003 academic year, with full implementation planned for fall 2003. Every local Head Start program will be required to assess all participants between the ages of three and five on these indicators at the beginning, middle, and end of each year and to analyze the assessment data on the progress and accomplishments of all enrolled children. Federal program monitoring teams will conduct on-site reviews of a program's implementation of these requirements. HHS is also designing a national reporting system to collect data from every local program. This system, together with ongoing Head Start research and from Head Start on-site program monitoring reviews, will create comprehensive information on local program effectiveness. Local program data will be used to target new efforts in staff training and program improvement to enhance the capacity of Head Start to increase children's early literacy and school readiness. In addition, data on whether a program is successfully teaching standards of learning will be used in HHS evaluations of local Head Start agency contracts." Good Start, Grow Smart, April 2002.

ACF is in the process of planning for the design and implementation of a national reporting system on child outcomes. The Head Start Bureau engaged in consultations with experts and stakeholders and plans to procure contractor support to implement the field test in the pilot year:

- The "Workshop on Children's Early Learning, Development and School Readiness: Conceptual Frameworks, Constructs and Measures," convened in consultation with NICHD and ASPE on June 17-18, 2002;
- A planning meeting, convened at NICHD on July 9, 2002, seeking recommendations from experts on child development and assessment on critical features for the field test of the National Reporting System, and issues surrounding the eventual full-scale implementation of the NRS;
- Develop specifications and award contract to implement field test activities and preparation for full implementation of the national reporting system, August 2002; and
- Implement field test of new assessment and reporting procedures in a representative set of local Head Start programs. The field test will examine the feasibility of implementing one or more approaches on key outcome areas and will pilot test approaches for assembling and analyzing this information in a national reporting system. September 2002-April 2003.

Developmental Measures

- 5.2o. FY 2004: Percentage of all Head Start grantees that are reporting child outcome data using the National Reporting System.**
- 5.2p. FY 2004: Proportion of Head Start grantees, using the National Reporting System that meet or exceed numerical targets in selected dimensions of school readiness.**

These measures will be under development in FY 2003 to pilot test the implementation and utilization of Head Start's National Reporting System of local child development outcomes.

6. INCREASE SAFETY, PERMANENCY, AND WELL-BEING OF CHILDREN AND YOUTH

Approach for the Strategic Objective: Help children and youth while they are living with their own families, when appropriate. When necessary, place children and youth in stable, family-like settings consistent with the needs of each child or youth. Support children and youth with developmental disabilities in individual and small group dwellings that will include them in community life.

6.1 CHILD WELFARE

Program Purpose and Legislative Intent

The purpose of ACF's Child Welfare programs is to prevent maltreatment of children in troubled families, protect children from abuse, and find permanent placements for those who cannot safely return to their homes. Programs such as Foster Care, Adoption Assistance, and Independent Living provide stable environments for those children who cannot remain safely in their homes, assuring the child's safety and well-being while their parents attempt to resolve the problems that led to the out-of-home placement. When the family cannot be reunified, foster care provides a stable environment until the child can be placed permanently with an adoptive family. Adoption Assistance funds are available for a one-time payment for the costs of adopting a child as well as for monthly subsidies to adoptive families for care of the child.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL - SAFETY: <i>Children are protected from abuse and neglect in their homes. The risk of harm to children will be minimized.</i>			
6.1a. Decrease the percentage of children with substantiated reports of maltreatment that have a repeated substantiated report of maltreatment within 12 months.	CY 01: Dropped CY 00: 11% CY 99: 12%	CY 00: 14% CY 99: 11% CY 98: 10%	
6.1b. Decrease the percentage of children with substantiated reports of maltreatment that have a repeated substantiated report of maltreatment within six months.	CY 04: 7% CY 03: 7% CY 02: 7% CY 01: 7% CY 00: NA	CY 04: 9/05 CY 03: 9/04 CY 02: 9/03 CY 01: 9% CY 00: 9% CY 99: 8% CY 98: 8%	Px 103 HHS 7.4
PROGRAM GOAL - PERMANENCY: <i>Provide children in foster care permanency and stability in</i>			

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
<i>their living situations.</i>			
6.1c. Maintain the percentage of children who exit the foster care system through reunification within one year of placement.	FY 04: 67% FY 03: 67% FY 02: 67% FY 01: 67% FY 00: 67% FY 99: NA	FY 04: 6/05 FY 03: 6/04 FY 02: 6/03 FY 01: 68% FY 00: 67% FY 99: 65% FY 98: 63%	Px 104 HHS 7.1/ 7.4
6.1d. Increase the percentage of children who exit care through adoption within two years of placement.	FY 04: 27% FY 03: 25% FY 02: 25% FY 01: 28% FY 00: 27% FY 99: NA	FY 04: 6/05 FY 03: 6/04 FY 02: 6/03 FY 01: 23% FY 00: 20% FY 99: 19% FY 98: 23%	Px 104 HHS 7.1/ 7.4
6.1e. Maintain percentage of children who exit foster care through guardianships within two years of placement.	FY 04: 62% FY 03: 60% FY 02: 60% FY 01: 67% FY 00: 67% FY 99: NA	FY 04: 6/05 FY 03: 6/04 FY 02: 6/03 FY 01: 57% FY 00: 59% FY 99: 64% FY 98: 70%	Px 104 HHS 7.1/ 7.4
6.1f. Increase the number of adoptions.	FY 04: 60,000 FY 03: 58,500 FY 02: 56,000 FY 01: 51,000 FY 00: 46,000 FY 99: 41,000	FY 04: 9/05 FY 03: 9/04 FY 02: 9/03 FY 01: 50,000 FY 00: 50,000 FY 99: 46,000 FY 98: 36,000 FY 97: 31,000 FY 96: 28,000 FY 95: 26,000	Px 104 HHS 7.1/ 7.4
6.1g. Twenty States will either increase the number of adoptions by relatives or the proportion of the adoptions by relatives over those in FY 2002	FY 03: Dropped		
PROGRAM GOAL - FAMILY AND CHILD WELL-BEING: Minimize the disruption to the continuity of family and other relationships for children in foster care.			
6.1h. For those children who had been in care less than 12 months, increase the percentage that had no more than two	FY 04: 64% FY 03: 62% FY 02: 60% FY 01: 72%	FY 04: 6/05 FY 03: 6/04 FY 02: 6/03 FY 01: 60%	Px 105 HHS

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
placement settings.	FY 00: NA FY 99: NA	FY 00: 58% FY 99: 60% FY 98: 70%	7.4
Total Funding (includes Independent Living/Foster Care/Adoption-dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$7917.0 FY 03: \$7574.4 FY 02: \$7485.2 FY 01: \$7197.8 FY 00: \$6463.4 FY 99: \$5639.7	Bx: budget just. sections Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

ACF has undertaken a number of activities designed to improve overall performance in child welfare. Most significant is the publication in January 2000 of final regulations pertaining to aspects of the Adoption and Safe Families Act of 1997 (ASFA), including regulations about foster care eligibility reviews and State plan reviews. Central and Regional Office staff and the ten Child Welfare Resource Centers continue to provide training and technical assistance to States and local agencies around issues pertaining to the implementation of ASFA. The Resource Centers focus on permanency planning, adoption, family-centered practice, youth development, legal issues, abandoned infants, organizational development, child maltreatment, community-based family resource services, and information technology.

On January 25, 2000, HHS published a final rule in the *Federal Register* to establish new approaches to monitoring State child welfare programs. Of particular note are the Child and Family Services (CFS) reviews, which focus on outcomes for children and families in the areas of safety, permanency, and child and family well-being; and systemic factors that directly impact the State's capacity to deliver services leading to improved outcomes. In FY 2004, at least one CFS review will have been completed in each State and some States will begin a second review. The specific outcomes and their associated indicators are as follows:

Safety Outcomes:

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their homes whenever possible and appropriate.

Permanency Outcomes:

- Children have permanency and stability in their living situations.
- The continuity of family relationships and connections is preserved for children.

Child and Family Well-Being Outcomes:

- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.
- Children receive adequate services to meet their physical and mental health needs.

The systemic factors being reviewed are related to the State's ability to deliver services leading to improved outcomes. The systemic factors include: 1) statewide information systems; 2) case review system; 3) quality assurance system; 4) staff and provider training; 5) service array; 6) agency responsiveness to the community; and 7) foster and adoptive parent licensing, recruitment and retention.

Finally, ACF continues to focus on child welfare outcomes. In addition to the outcomes measured through the CFS reviews, ACF publishes an annual report on Child Welfare Outcomes for the States required by section 479a of the Social Security Act and awards adoption incentive funds to States that increase their number of finalized adoptions over their baselines. Harvard University has recognized ACF's achievements in its focus on outcomes in child welfare activities. ACF was one of 15 finalists out of 3,000 applicants in Harvard University's Innovations in American Government competition.

Program Partnerships

ACF's ability to promote improvement in child welfare services is dependent on working collaboratively with State child welfare agencies that are responsible for providing direct services to children and their families. This relationship has been significantly strengthened through the State-Federal partnership required and promoted by the CFS reviews. However, decisions about placing children are made by judges in juvenile and family court systems throughout the nation. Improved judicial handling of child welfare cases will be essential to achieving permanency goals for children. Children in the child welfare system have many medical and mental health problems, while chronic substance abuse, mental health problems, homelessness, limited education, and other problems incapacitate many of their parents. The availability of services from other sectors to meet these needs is uneven. The expansion or contraction of services in various parts of the country will affect performance.

To ensure that activities are coordinated with Federal partners which provide many of these services, ACF works closely on achieving its goals with the Department of Justice, the Substance Abuse and Mental Health Services Administration, the Temporary Assistance for Needy Families program and other national agencies and organizations whose responsibilities overlap with child welfare services.

PROGRAM PERFORMANCE ANALYSIS

Performance Report

ACF exceeded the goals for one of the five measures for which FY 2001 data are currently available (August 2002). Over 110,000 (68 percent) children who exited foster care through reunification did so within one year of placement (6.1c).

For two goals, the movement was in the right direction. The percentage of children who exited care through adoption within two years of placement increased from 20 percent in FY 2000 to 23 percent, over 10,000 children, in FY 2001 (6.1d). In addition, sixty percent, 33,000, of the children who had been in care less than 12 months experienced no more than two placement settings. A third goal, increase the number of adoptions to 51,000 in FY 2001, was missed by 1,000 (6.1f). However, the goal for the total number of adoptions from FY 1999 to FY 2001 was 138,000. The total number of adoptions actually finalized during this period, 146,000, exceeded the total target by 8,000.

The percentage of children who exited foster care through guardianships within two years of placement declined from 59 percent in FY 2000 to 57 percent (4,500) in FY 2001 (6.1e). Finally, the 12-month substantiated maltreatment recurrence rate (6.1a) increased from 11 percent to 14 percent between CY 1999 and CY 2000. This is most likely a result of the complexity in the calculation of this measure and the substantial change in the number of States reporting useable data. Nineteen States reported useable data for CY 1998, 23 States for CY 1999, and 30 States for CY 2000. The new measure of the six-month substantiated maltreatment recurrence rate (6.1b) to be used beginning in CY 2001 has proven to be more stable over time, ranging between eight percent and nine percent for the years CY 1998 through CY 2001. Forty States reported useable data for the CY 2001 calculation.

It should be noted that the three goals which are included as standards in the CFS reviews and for which data are available either exceeded their targets or moved in the right direction (6.1c, 6.1d, 6.1h). Two of these goals, 6.1c and 6.1d, are also directly affected by provisions of ASFA, particularly the change in the timing of the permanency hearing from 18 months to 12 months after removal. In addition, more detailed analyses of the Adoption and Foster Care Reporting and Analysis System (AFCARS) data have confirmed that the time to reunification and adoption is accelerating.

The reason goal 6.1f (increase the number of adoptions) was missed for the first time in FY 2001 was because most of the children who had been on the adoption track prior to the implementation of ASFA have completed the adoption process. Concurrently, many of the children who entered the adoption track after implementation of ASFA have not yet completed the process.

It is unclear whether or not the percentage of children who exited foster care through guardianships within two years of placement (6.1e) actually declined or if the figures are a reflection of data improvement. Guardianship, as a reason for discharge, has generally been under-reported and does not even exist as a discharge reason in some States. However, the

number of guardianships reported doubled between FY 1998 and FY 2001, from a little over 4,000 to 8,000.

There are a number of factors that have contributed to this increase in reporting. First, the use of guardianship as an exit strategy for relative foster care appears to be growing, primarily for children who may have been in a relative care placement for a long period of time, and many States wish to track it. Second, AFCARS reviews have identified problems in the coding of guardianships in a limited number of States and those States have taken action to correct the problems. Third, the Data Profile component of the Statewide Assessment used in the CFS emphasizes discharge reasons.

When States identify problems with the reporting of guardianships or other discharge reasons in their profile, they review and frequently resubmit their data. Early indications are that this process has generated improved data for those States that underwent CFS reviews in FY 2001 and FY 2002. Finally, the ACF-funded National Resource Center for Information Technology in Child Welfare is providing intensive technical assistance to States undergoing CFS reviews, particularly in relation to the Data Profile in the Statewide Assessment. ACF expects this technical assistance to result in an overall improvement in the reporting of discharge reasons.

A developmental measure (6.1g) proposed in the FY 2003 Performance Plan has been dropped. This measure fails to focus on permanency outcomes for children in foster care. In contrast, it focuses on a certain type of potential adoptive parent—a relative. Since there are no data to support superior outcomes for children adopted by any particular group—relatives, foster parents, or persons with no prior relationship to the child—ACF does not plan any activities specifically designed to promote adoption by relatives. (It should be noted that the increase in some States in the number of adoptions by relatives was not the focus of any activity promoting relative adoption, but was a by-product of initiatives promoting guardianship.) Measure 6.1f more than adequately assesses the output of adoption and measure 6.1d assesses the timeliness of adoption, both of which are directly related to the permanency outcome.

The following table has been included to illustrate how ACF is investing FY 2002 resources to improve outcomes for children and their families in the child welfare system. It should be noted that many dollars contribute to more than one outcome and, therefore, may be included up to three times in this table. In addition, some outcomes such as Family and Child Well-Being may require as many FTE as Safety and Permanency even though fewer dollars are available to spend on the related activities.

**BUDGET TABLE LINKING INVESTMENTS TO
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcome
\$5.8 billion	Training & Technical Assistance; monitoring of State programs; discretionary and formula grants to States,	Children reported to child protective services for maltreatment; investigated and substantiated for	Safety: children are protected from abuse and neglect in their homes. The risk of harm to children will be

	foster care entitlement; and data collection, research and demonstrations.	maltreatment; and recurrence of maltreatment.	minimized.
\$7.2 billion	Training & Technical Assistance; monitoring of State programs; formula grants to States; and data collection.	Children re-united with family or other relatives, adopted, or in permanent guardianship.	Permanency: Provide children in foster care permanency and stability in their living situations.
\$1.8 billion	Training & Technical Assistance; monitoring of State programs; and formula grants to States.	Children and families in the public child welfare system receive services that enhance their ability to relate to each other and to others.	Family And Child Well-Being: Minimize the disruption to the continuity of family and other relationships for children in foster care.
\$1.4 billion	Training & Technical Assistance; monitoring of State programs; formula grants to States, and data collection	Youth exit care with skills to live on their own.	Foster Care Youth are prepared to live on their own.

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

Both AFCARS and the National Child Abuse and Neglect Data System (NCANDS) conduct extensive edit-checks for internal reliability. For AFCARS, more than 700 edit-checks are conducted to improve data quality and the results are sent to the States. In addition, all edit-check programs are shared with the States. Finally, compliance reviews for AFCARS are currently being piloted and State SACWIS systems are undergoing reviews to determine the status of their operation.

To speed improvement in these data, the agency funds the National Resource Center for Information Technology in Child Welfare. This Resource Center provides technical assistance to States to improve reporting to AFCARS and NCANDS, improve statewide information systems, and better utilize their data. These activities should continue to generate additional improvements in the data over the next few years.

Being able to report data in a timely manner is critical in guiding program improvement to achieve outcomes. The following summarizes why AFCARS foster care data are not available until nine months after the September 30 point-in-time date. AFCARS foster care data for September 30 of any year, under regulation, are reported by the States to ACF electronically by November 14. The data are processed, assessed for errors and compliance with regulatory standards, and the results are transmitted back to the States. Based on these results and other information provided by the Department, many States submit revised data to insure that accurate data are submitted. There are two other reasons States re-submit data. First, AFCARS foster care

data are used in the statewide assessment portion of the CFS reviews. When some States examine these data provided to them by the Department, they chose to re-submit more accurate data. In addition, AFCARS foster care data are used in the implementation of Program Improvement Plans, which result from the CFS reviews. States may resubmit data to insure that the data used for this purpose are accurate. The resubmitted data are then processed and the data are made available to the statistical analysts in May. The analysts review the data to determine which States' data are useable in this plan.

The AFCARS adoption data take a longer time to become available because States can submit data on any finalized adoption and still meet the requirements of the regulation. Frequently, adoption data are not entered into State information systems for some time after the adoption because the entry does not occur until the final paperwork is received from the court. For example, over 2,800 adoptions finalized in FY 2000 were not reported until the first reporting period in FY 2001, or by May 15, 2001. Because of the requirement of the Adoption Incentive Program that only adoptions reported by the first reporting period in the following fiscal year can be counted for incentive awards, almost all adoptions are now reported within that timeframe, though there are still a small number which are reported in subsequent reporting periods. After data are received (in this case by May 15 of the following year), they still must be downloaded, converted to analytical files and cleaned before they can be included in the plan.

The NCANDS data take even longer to become available. Data reported to NCANDS only once per year which delays the calculation of recurrence. For example, for a 12-month recurrence rate, for FY 2001, a first report could occur as late as December 31, 2001. To count as a recurrence, a second report can be received as late as December 2002. The NCANDS data are then compiled by the States, transmitted to the contractor, converted to analytical files, de-duplicated and cleaned before they are available to include in the plan. By replacing the measure (6.1a) to recurrence within six months (6.1b), the timeline is shortened by one year because the first occurrence can occur during the first six months of the year and the second occurrence only has to occur during the second six months of the year of interest. This makes the data available in early fall of the subsequent year. The information for 6.1a for CY 1998 is based on 19 States reporting and, for CY 1999, on 23 States. Due to the varying number of States reporting on this measure and on 6.1b, data are expected to continue to fluctuate.

Performance Plan

PROGRAM GOAL - SAFETY: Children are protected from abuse and neglect in their homes. The risk of harm to children will be minimized.

6.1b. FY 2003: *Decrease the percentage of children with substantiated reports of maltreatment that have a repeat substantiated report of maltreatment within 6 months from eight percent in CY 1998 to seven percent in CY 2003.*

FY 2004: *Decrease the percentage of children with substantiated reports of maltreatment that have a repeat substantiated report of maltreatment within 6 months from eight percent in CY 1998 to seven percent in CY 2004.*

Data Source: National Child Abuse and Neglect Data System (NCANDS)

PROGRAM GOAL - PERMANENCY: Provide children in foster care permanency and stability in their living situations.

- 6.1c. FY 2003:** *Of the children who exit the foster care system through reunification, maintain the percentage of children who do this within one year of placement at 67 percent.*

FY 2004: *Of the children who exit the foster care system through reunification, maintain the percentage of children who do this within one year of placement at 67 percent.*

Data Source: AFCARS

- 6.1d. FY 2003:** *Of the children who exit foster care through adoption, increase the percentage who are adopted within two years of placement from 23 percent in FY 1998 to 25 percent in FY 2003.*

FY 2004: *Of the children who exit foster care through adoption, maintain the percentage that are adopted within two years of placement at 27 percent in FY 2004.*

Data Source: AFCARS

- 6.1e. FY 2003:** *Of the children who exit foster care through guardianships, maintain the percentage of children who do this within two years at 60 percent.*

FY 2004: *Of the children who exit foster care through guardianships, increase the percentage of children who do this within two years to 62 percent.*

Data Source: AFCARS

- 6.1f. FY 2003:** *Make progress towards increasing the number of adoptions of children in the public foster care system between FY 1998 and FY 2003 by increasing adoptions from 36,000 in FY 1998 to 58,500.*

FY 2004: *Increase the number of adoptions to 60,000 as the initial step in achieving the goal of finalizing 300,000 adoptions from FY 2004 through FY 2008.*

Data Source: Baselines from the Adoption Incentive Program and the Adoption 2002 Initiative for FY 1997 and AFCARS for all subsequent years.

- 6.1g. FY 2003: *Twenty States will either increase the number of adoptions by relatives or the proportion of the adoptions by relatives over those in FY 2002. (Dropped)***

This measure was dropped because it fails to focus on permanency outcomes for children in foster care and focuses on a certain type of potential adoptive parent – a relative. ACF does not plan any activities specifically designed to promote adoption by relatives.

PROGRAM GOAL - FAMILY AND CHILD WELL-BEING: Minimize the disruption to the continuity of family and other relationships.

- 6.1h. FY 2003: *For those children who have been in care less than 12 months, increase the percentage who had no more than two placement settings to 62 percent.***

FY 2004: *For those children who have been in care less than 12 months, increase the percentage who had not more than two placement settings to 64 percent.*

Data Source: AFCARS

PROGRAM GOAL - PREPARE FOSTER CARE YOUTH FOR INDEPENDENT LIVING: (a) enhance the education, employment and other skills of foster care youth to avoid dependency; and (b) expand opportunities for youth to achieve self-sufficiency while under the auspices of the public child welfare agency.

In FY 2000, Congress passed legislation authorizing a substantial increase in funds for independent living services for foster care youth under title IV-E of the Social Security Act. These services prepare them for independent living by enhancing their education, employment and other skills to avoid dependency; and by expanding opportunities for youth to live independently while under the auspices of the public child welfare agency. This legislation requires developing and implementing outcome measures and a data collection system for this program.

In FY 2003, ACF will finalize the outcomes to be tracked, data collection strategy, and the data elements to be collected. By FY 2004 and FY 2005, it is expected that we will have baseline data for the specific outcomes.

6.2 DEVELOPMENTAL DISABILITIES (EDUCATION)

The DD education goal is to increase the number of students with developmental disabilities who reach their educational goals. In order to reduce the total number of measures for the DD program, this performance measure is being dropped from the plan effective FY 2003.

(See information on DD program purpose and legislative intent under Strategic Objective 1, above.)

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Increase the number of students with developmental disabilities who reach their educational goals.			
6.2a. Increase the number of students with developmental disabilities who are served in more integrated/inclusive educational settings as a result of DD program intervention. (Dropped)	FY 03: Dropped FY 02: 11,500 FY 01: 11,000 FY 00: 8,800 FY 99: 8,000	FY 02: 3/03 FY 01: 10,288 FY 00: 10,054 FY 99: 10,901 (Baseline)	Px 107 HHS 6.3

PROGRAM DESCRIPTION AND CONTEXT

As described under Strategic Goal 1, the State Council, the UCEDD(s), and the P&A system in each State contribute to pursuing integrated/inclusive education for persons with developmental disabilities in accordance with State legislation. The P&A systems usually have the lead in promoting the development of integrated/inclusive education for persons with developmental disabilities. P&A interventions included counseling parents on advocating for their children, negotiating better placements, counseling school systems on the rights of students with disabilities, administrative remedies, and, in extreme cases, litigation.

PROGRAM PERFORMANCE ANALYSIS

The achievement of this performance target is principally affected by attitudes in each State about the desirability of educating youth with disabilities. In a less significant way, the education cost is influenced by economic factors in each State.

Performance Report

The reported number of students with developmental disabilities served in more integrated, inclusive educational settings (measure 6.2a) has fluctuated considerably in years prior to FY 1999. These fluctuations were caused by inconsistencies in State methods for reporting and setting performance targets and decisions States made to target resources at the changing needs in the service environment. In FY 2001, P&A systems in all 56 States and territories reported results for a total of 10,288 students with developmental disabilities served in more integrated/inclusive educational settings as a result of P&A system intervention. Although this is a 6.5 percent shortfall from the FY 2001 target, it represents an increase of 234 students over the FY 2000 actual performance.

Data Issues

Many of the same data issues discussed in the context of DD employment measures under Strategic Goal 1 affect the integrated/inclusive education measure (6.2a). P&A systems generate both target and outcome data for this indicator and submit target data to ACF via the EDS system as part of their Statement of Goals and Priorities (SGP). P&A systems submit the outcome data to ACF in the legislatively mandated Program Performance Report (PPR) which is also submitted on the EDS system. Both the SGP and the PPR are submitted annually on January 1.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

- 6.2a FY 2003: Increase the number of students with developmental disabilities who are served in more integrated/inclusive educational settings as a result of DD program intervention. (Dropped).**

This measure has been dropped. It was determined that the data are not a good measure of program effort or impact. ADD will focus on employment, housing, health and community support measures.

6.3 DEVELOPMENTAL DISABILITIES (HEALTH)

The DD health care goal is to improve the health of people with developmental disabilities and increase their access to the full range of needed health care services. This goal comprises issues such as access to health care information needed to make choices, the affordability, accessibility, and equitable distribution of health care resources. Significantly, health care personnel must be appropriately qualified to meet the health care needs of people with developmental disabilities. This indicator contributes to the New Freedom initiative in focusing on promoting access to healthcare.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Improve the health of people with developmental disabilities and increase their access to the full range of needed health care services.			

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
6.3a. Increase the number of health care providers trained to meet the health needs of people with developmental disabilities as a result of DD program intervention.	FY 04: 4,350 FY 03: 4,200* FY 02: 4,200 FY 01: 5,000 FY 00: 4,825 FY 99: 4,000	FY 04: FY 03: FY 02: 1/03 FY 01: 4,112 FY 00: 4,032 FY 99: 4,100 Baseline FY 98: 3,733	Px 109 HHS 3.5
* FY 2003 target adjusted by DD partners to reflect more realistic expectations.			

PROGRAM DESCRIPTION AND CONTEXT

The State Council and the UCEDD(s) in each State contribute to pursuing training for health care providers. The UCEDDs serve as lead partners as required by their legislative mandate to provide training.

PROGRAM PERFORMANCE ANALYSIS

Health care provider training data is influenced by the need for UCEDDs to focus on an array of disabilities issues that impact on persons with developmental disabilities. Performance for this measure is affected by factors such as the cost of providing health care generally, and especially to people with disabilities. Access to health care is affected by social attitudes concerning the desirability and potential for people with developmental disabilities to benefit from full access to health care and the attitudes of health care providers toward this special needs population.

Because so few health care professionals are aware of the special health care needs of persons with developmental disabilities, there is a significant need for training. Actual performance remains unstable due to changes in allocation of training resources, but ACF believes there is potential for gradual improvement.

Performance Report

In FY 2001, UCEDDs reported 4,112 health care providers trained to meet the needs of people with developmental disabilities. This was a slight increase over both of the preceding years, but fell 18 percent short of the target for FY 2001.

Data Issues

UCEDDs generate both target and outcome data for this indicator. The data on the targets and outcomes is collected nationally as part of their UCEDD Annual Report. ACF's technical assistance to University programs will improve data stability and programmatic outcomes.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

Performance for this measure in FY 2004 is projected to increase slightly from the actual level in FY 2001 but it is below the target of 5,000 set for FY 2001. The targets for FY 2003 and FY 2004 are based on actual performance in FY 2000 with expectation of increases due to increases in core funding beginning in FY 2002.

PROGRAM GOAL: Improve the health of people with developmental disabilities and increase their access to the full range of needed health care services.

Objective: Increase the number of health care providers trained to meet the health needs of people with developmental disabilities.

6.3a. FY 2003: *Maintain at 4,200 the number of health care providers trained to meet the health needs of people with developmental disabilities as a result of DD program intervention.*

FY 2004: *Increase to 4,350 the number of health care providers trained to meet the health needs of people with developmental disabilities as a result of DD program intervention.*

Data Source: UCEDD annual report

6.4 YOUTH PROGRAMS

Program Purpose and Legislative Intent: The purpose of the Runaway and Homeless Youth Program is to establish and operate local runaway and homeless youth shelters; to address the needs of runaway and homeless youth and their families; to provide residential services to older youth; and to offer outreach services to street youth. Grants to local public and private organizations are used to develop or strengthen community-based programs that are not a part of the law enforcement, juvenile justice, child welfare and mental health systems. Prevention services for youth at risk for running away are also provided.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL I: Provide appropriate shelter, counseling and other support services to youth and their families in high-risk situations.			
6.4a.1. Establish at X percent the proportion	FY 01: 96% FY 00: 95%	FY 01: NA FY 00: 83%	

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
of youth living in safe and appropriate settings after exiting ACF-funded services. (Revised baseline, using FY 2002 data from the new instrument, will be established during FY 2003.) (Replaced by 6.4a.2. in FY 2002.)	FY 99: 95%	FY 99: 86% FY 98: 81% FY 97: 82%	
6.4a.2. Increase to X+y percent the proportion of youth living in safe and appropriate settings after exiting ACF-funded services. (Revised baseline, using FY 02 data from the new instrument, will be established during FY 03.) (Developmental.)	FY 04: TBD FY 03: TBD	FY 04: FY 03: FY 02: 81.3%* baseline	Px 119 HHS 7.4
*FY 2002 baseline is not comparable to previous years due to new categories and definitions of RHYMIS.			
PROGRAM GOAL II: Prevent or mitigate severe youth crises by maintaining the credibility of RHY services among youth.			
6.4b. Increase the proportion of youth that call the National Runaway Switchboard when they are contemplating running away but before they do so.	FY 03: Dropped FY 02: N/A	FY 02: 10% FY 01: 11% FY 00: 9% FY 99: 9%	Px 119
6.4c. Maintain the proportion of youth that contact the National Runaway Switchboard for counseling and referral to safe shelter or other services, earlier rather than later in their runaway episode (up to the first week). (Developmental)	FY 04: TBD FY 03: 68%* FY 02: 68%	FY 04: FY 03: FY 02: 65% FY 01: 66% FY 00: 65% FY 99: 63%	Px 119 HHS 7.4
*FY 2003 target revised; FY 2004 target to be determined in FY 2003.			
PROGRAM GOAL III.A: Increase the involvement of youth in service to their communities.			
6.4d. Establish and maintain the number of BC and TLP youth engaged in activities that help others or the community through community service and service learning. (Developmental)	FY 04: TBD FY 03: TBD	FY 04: FY 03: FY 02: 8465 (Baseline)	Px 120
6.4e. Establish and maintain the proportion of BCP and TLP youth receiving peer counseling through program services. (revised target. FY 97 baseline was 12 percent)	FY 02: Dropped FY 01: 15% FY 00: 15%	FY 01: NA FY 00: 8% FY 99: 12% FY 98: 12% FY 97: 12%	

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL III.B: Strengthen youth in reaching their full potential socially and economically by providing opportunities that move them toward self-sufficiency.			
6.4f. Increase the number of youth in the transitional living programs who successfully complete the program. (Developmental)	FY 04: TBD FY 03: TBD	FY 04: FY 03: FY 02: 48%* (Baseline)	Px 120 HHS 7.4
* Based on numbers/percentages below:			
Completed TLP:	588	21%	
Other Opportunities	766	27%	
Voluntarily Did Not Complete TLP, No Plans	704	25%	
Youth was Expelled or Otherwise Involuntarily Charted	745	27%	
Total	2803	100%	
PROGRAM GOAL III.C: Build partnerships across governments, with communities, and with youth to help youth develop as individuals and as citizens.			
6.4g Maintain at 13 States and youth services grantees in those States a collaboration that supports a youth development approach to services for young people, including substance abuse and teen pregnancy prevention activities and add additional States as resources become available.	FY 03: Dropped FY 02: 13 FY 01: 13 FY 00: 9 FY 99: 5	FY 02: 13 FY 01: 13 FY 00: 13 FY 99: 9	Px 120
PROGRAM GOAL IV: Youth in Transitional Living programs achieve good mental and physical health and a greater sense of optimism, empowerment and possibility.			
6.4h. Increase the number of youth in Transitional Living Programs who are provided tools, training, and experiences to feel prepared for life as measured by youth who complete high school/GED, receive skills or job readiness training and/or secure employment. (Developmental)	FY 04: TBD FY 03: NA	FY 04: FY 03: Baseline	Px 121 HHS 6.1
Total Funding (dollars in millions) See detailed Budget Linkage Table in Part I for items included in funding totals.	FY 04: \$113.0 FY 03: \$113.1 FY 02: \$103.0 FY 01: \$ 84.1 FY 00: \$ 79.2 FY 99: \$ 76.5	Bx: budget just. Section Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

The Runaway and Homeless Youth (RHY) Program began in 1974 in response to concern about increasing numbers of runaway youth exposed to exploitation and the dangers of street life. It has subsequently been expanded to assist homeless youth both on a short-term basis and in making the transition to independent living. In FY 2002, ACF's Basic Center and Transitional Living programs provided shelter and services to over 78,000 youth. The Street Outreach Program reached 519,955 youth (duplicated count) and included the distribution of 289,384 food and drink items or packages, 432,073 written materials (e.g., brochures or fliers) and 493,272 health and hygiene products. TLP and BCP staff engaged in 211,486 "brief" service deliveries to youth, their families or through contacts with other responsible adults or professionals on behalf of youth. These involved counseling, listening, conversations, referrals, advice and other interactions that touched the lives of youth but may not have resulted in admission to the center or program and being recorded in RHYMIS. Youth may have dropped by a center for reassurance or guidance and did not stay overnight; in some cases possibly returning home with a "new perspective."

The Runaway and Homeless Youth Act of 1999, as reauthorized, requires that at least 90 percent of the funds be spent on service grants. The balance supports a national hotline for runaways, an information clearinghouse, demonstration projects, data collection, on-site program monitoring and other support functions.

The size and composition of the young homeless population varies with the economy, local and national demographics, community viability, school quality, family dynamics, and other factors. Many youth served in the RHY programs seek assistance because of problems with parental substance abuse, emotional, sexual and/or physical abuse and neglect, or other adolescent/parental relationship issues. Others are caught up in the turmoil of adolescence and need support in coping with the stresses in their lives. These factors complicate service delivery, aftercare follow-up, and achievement of desirable outcomes.

Estimates of the number of runaway and homeless youth in the United States vary, ranging from 500,000 to 1.5 million. A recent projection suggested that as many as 2.8 million youth in America reported a runaway experience in the year preceding the study. In FY 2002, FYSB collaborated with the Office of Planning, Research and Evaluation and the HHS Office of the Assistant Secretary for Planning and Evaluation to begin a Congressionally mandated study of the feasibility of various means to more accurately count the number of runaway and homeless youth.

The Maternity Group Homes Program helps protect and support some of the most vulnerable of America's families and the vital role they play in the nation's future. The need is especially great for young pregnant mothers and their children who lack safe and stable environments in which to live. These women are vulnerable to abuse and neglect and often end up on welfare, in foster care, in homeless shelters, or on the streets and their children are at high risk of being teen parents themselves. The Maternity Group Homes amount of \$10 million will fund approximately

53 continuation grants to provide a range of coordinated services such as child care, education, job training, counseling and advice on parenting and life skills to young mothers.

Positive Youth Development: Fundamental to ACF's approach to youth programs is the concept of Positive Youth Development (PYD), which promotes the strengths and abilities of youth and the positive impact they can have on the nation's communities. The PYD approach maintains that youth nurtured by caring adults, given opportunities to become involved in work or education that builds their skills, supported and protected during challenging times, and actively engaged in service to the community can become valuable contributors to the quality of community life.

In FY 2001, the Assistant Secretary designated PYD as a key priority of ACF. In June 2002 FYSB, working with its partners, sponsored a major National Youth Summit which focused across disciplines and service areas on issues supporting PYD.

Over the past several years, FYSB has sponsored a number of efforts to broaden and re-emphasize the agency's PYD-related mission. FYSB encourages communities to provide the settings and services needed for young persons' healthy growth and development. The following "life and character components" are essential in the development of youth:

- Safe places with structured activities;
- Ongoing relationships with caring adults;
- Marketable skills through effective education and training;
- Healthy choices and hopeful futures; and
- Opportunities to give back through community service.

If these factors are addressed at the same time as basic needs – such as safety, security, good nutrition, access to health care and other essential services – young people can engage constructively in their communities and society.

Related to its PYD focus, FYSB has established grant programs that target support in several key areas. These include the following:

- **Basic Center Program (BCP):** Grants for the provision of outreach crisis intervention, temporary shelter, counseling, family unification and aftercare services to runaway and homeless youth and their families.
- **Transitional Living (TLP) and the Maternity Group Homes Programs:** Grants to public and private organizations to support projects that provide longer-term residential services for up to 18 months to homeless youth, including pregnant and parenting youth ages 16-21.
- **Street Outreach Program (SOP):** Grants to private, non-profit agencies for street-based outreach and education, including treatment, counseling, provision of information, and referral for runaway, homeless street youth.

Program Partnerships

FYSB collaborates with other Federal agencies, other ACF programs, States and community organizations to achieve its mission. FYSB funds State Youth Development Collaboration Projects to support innovative youth development strategies and capacity building at the State level. The five-year grants enable the States to develop new, or strengthen existing, youth development infrastructures, partnerships and policies. These efforts focus on all youth, including those at-risk, such as runaway and homeless youth, those leaving the foster care system, abused and neglected children, and others served by the child welfare and juvenile justice systems.

FYSB and the ACF Children's Bureau (CB) are entering their eighth year of collaboration to promote the PYD philosophy and approach in services to foster care and homeless youth, with particular reference to expanded funding under the Chaffee Independent Living Program (ILP). FYSB's TLP grantees have valuable experience in helping disadvantaged older youth transition to a healthy and productive adulthood; thus, FYSB is helping CB's ILP connect with these community resources.

FYSB works with agencies across HHS and other public, private, and non-profit entities to encourage use of the youth development framework in providing effective services to young people through many work groups directed at the problem of homelessness, adolescent health, HIV/STD prevention among street youth, and other issues.

PROGRAM PERFORMANCE ANALYSIS

The following chart is illustrative of a general correlation between interventions and outcomes. It includes many youth with multiple issues and service experiences. Issues and services have been combined into similar categories and grouped in a horizontal "problem...solution" format for representational purposes only. The continuation of an "issue" row into a "services" row does not imply that a discrete group of youth with a given issue receive only that service or that the corresponding service directly on the right is always the treatment of choice. Obviously, some correspondences are multiple. However, it is useful to observe generic correspondences, e.g., between the number of housing issues identified and the provision of alternative housing solutions.

Issues Reported by Runaway and Homeless Youth During FY 02*	# of Youth	RHY Services Provided to Runaway and Homeless Youth During FY 02 *	# of Youth
(*Based on 70,718 youth. Shelter and other basic needs are provided to all program youth. Many youth enter the RHY programs with multiple issues, for which multiple services are appropriate.)			
Alcohol and Other Drug Abuse	17,786	Alcohol and Other Drug Treatment or Prevention	38,859
Household Dynamics	62,795	Basic Support Services	78,079
Psychological Issues	22,158	Counseling/Therapy	81,439
Physical, Sexual or Emotional Abuse/ Neglect/Assault	21,119	Support Groups	8,390
Mental Health	22,158		
Sexual Orientation/Gender Identity	2,819		

Issues Reported by Runaway and Homeless Youth During FY 02*	# of Youth	RHY Services Provided to Runaway and Homeless Youth During FY 02 *	# of Youth
(*Based on 70,718 youth. Shelter and other basic needs are provided to all program youth. Many youth enter the RHY programs with multiple issues, for which multiple services are appropriate.)			
Mental Disability	1,821	Life Skills Training/Legal Services	50,572
Physical Disability	624	Employment	7,092
Unemployment	8,722		
Housing Issues	20,931		
Health Issues	6,234	Health Care	18,466
		Recreational Activities	39,400
School/Education Issues	35,793	Youth Education	24,040
Total*	223,050	Total*	346,337

The following chart illustrates changes in living situation resulting from community-based RHY program operations. The upper half of the charts represents generally positive outcomes and the lower half generally negative. Note that most youth return to the homes of parents, guardians or relatives. See also measure 6.4a. (This chart's format is only illustrative and is not meant to imply that an individual youth in the "entrance" column exited into the (identical) situation in the same row.)

Living Situation at Entrance	# of Youth	Living Situation at Exit	# of Youth
Parent/Guardian's Home	51,578	Parent/Guardian's Home	43,132
Relative or Friend's Home	6,535	Relative or Friend's Home	5,040
Basic Center	1,004	Basic Center (including elsewhere in US)	560
Drug Treatment Center	174	Drug Treatment Center	309
Educational Institute	63	Educational Institute	81
Foster Home	3,391	Foster Home	3,513
Group Home	1,245	Group Home	1,987
Independent Living Program	97	Independent Living Program	303
Job Corps	76	Job Corps	125
Living Independently	529	Living Independently	882
Mental Hospital	498	Mental Hospital	843
Military	18	Military	41
Other Adult's Home	879	Other Adult's Home	671
Other Institution	215	Other Institution	439
Parent/Spouse	86	Partner/Spouse	49
Residential Treatment	422	Residential Treatment	723
Transitional Living Program	298	Transitional Living Program	814
Other Youth Emergency Shelter	809	Other Youth Emergency Shelter	736
Correctional Institute	1,833	Correctional Institute*	1,445
Other Temporary Shelter	558	Other Temporary Shelter	753
Other (in another living situation)	738	Other (in another living situation)	878
Homeless Shelter	461	Homeless Shelter	188
Homeless Family Center	269	Homeless Family Center	194
		Total "safe & appropriate" exits **	63,706
On the Street	5,591	On the Street	4,232

Living Situation at Entrance	# of Youth	Living Situation at Exit	# of Youth
Unknown situation before entry	981	Do not Know ***	3,221
		Total not "safe & appropriate" exits	7,453
		<i>(Total exit situations)</i>	<i>71,159</i>
Total Entrances ****	78,348	Total "safe and appropriate" exits as a percentage of total entrances	81.3%

*Placement in a correctional institute may be appropriate or necessary depending on the legal situation. Youth's previous status in the justice system may force this outcome.

** Youth may have "run away" from program or an older youth may have chosen to leave.

*** Youth may not have explained reason or disclosed destination

****Entrances are more numerous than exits because some youth who entered during the reporting period may still be in the programs when the reporting period ends.

Performance Report

In recent years, from 55,000 to more than 75,000 runaway or homeless youths have been reported "admitted to services" on an annual basis, as counted by formal enrollments in the Runaway and Homeless Youth Management Information System. These services included food, shelter, clothing, transportation, counseling and life skills training, recreation, substance abuse prevention, education, and health care. New data from improved collection methods, collected during FY 2002, indicate an increased number of youth and families were served by the RHY system. While some interventions may be brief or temporary (and not result in formal enrollment), they may have intrinsic, and sometimes lasting, value for the youth, the family, and the community.

FY 2001 data consisted of a very uneven mixture of data reported via the old system for the first half of the year with RHYMIS-LITE data reported from April onward after OMB approved the information collection. During the remainder of FY 2001, grantees received, installed, trained, and operated the new software. We are unable to report on the two measures that were dropped or replaced in FY 2001-2002: measure 6.4a.1 was replaced by 6.4a.2 and measure 6.4e was dropped. ACF will project targets for FY 2003-2004 based on the new baselines provided for measures 6.4a2, 6.4d and 6.4c.

The following table links FY 2002 investments to program outcomes:

**BUDGET TABLE LINKING INVESTMENTS TO
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcome
\$ 94.2 million	Discretionary service grants	648 Basic Center, Transitional Living and Street Outreach Programs	Over 75,000 youth rescued from at-risk situations, numerous runaway episodes prevented, numerous young people guided onto the right path toward adulthood
\$ 2.2 million	Promotion of quality services and positive youth development approach to working with and serving youth	10 training and technical assistance providers	RHY service quality improvement
\$ 5.0 million	Program support through several grants and contracts to provide: 24/7 National Runaway Switchboard, logistics, data collection, and information clearinghouse services	• Switchboard receives 120,000 calls/year. • Logistics contract supports onsite monitoring. • Data is produced for Congress and research community. • Clearinghouse information and publications serve the field.	Crisis intervention hotline for youth in at-risk situations, program accountability, RHY service quality improvement, knowledge increase,
<i>(included in \$5.0 million above)</i>	Promotion of the PYD approach to working with and serving youth (conference budget provided by clearinghouse)	National Youth Summit. June 26-28	Knowledge and awareness about principles of positive youth development increased, new partnerships, relationships and collaborations established, best practices disseminated

\$ 1.3 million	Promotion of the PYD approach to working with and serving youth	13 State youth development collaboration demonstration projects	New, innovative and more effective collaborations established across state agency lines and between State and local levels, new funds leveraged, youth, families and communities engaged (evaluations pending)
\$ 400,000	Evaluations including State youth development collaboration projects	9 project evaluation reports for first group of States (13 in all)	Increased knowledge about more effective governance and delivery of youth services at the State and local level

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data issues

Performance achievements among specific measures cannot be evaluated with the data available prior to FY 2002 due to data issues such as unreliability. Improvements in the Runaway and Homeless Youth Management Information System (resulting in an entirely new data collection system called RHYMIS-LITE) have significantly increased grantee compliance with data submission requirements. This trend is expected to be maintained as grantees become increasingly aware of the new ease in reporting and the many ways they can use the RHYMIS data to improve their reporting and evaluation processes. FYSB has also engaged in energetic messaging and advocacy among grantees and their allies about the importance of data in telling the RHY story to policymakers and legislators through GPRA and the Report to Congress. Under the new system, grantees need less time for reporting and can spend more time helping youth.

RHYMIS-LITE is a Windows application with a browser-like interface, with built-in validation, verification and quality assurance routines to help grantees produce high quality data. The RHYMIS Technical Support team assists those agencies submitting problematic transfers or failing to report and works to determine the underlying source of difficulty. Grantees are then able to address input problems and re-submit data before the reporting period ends. The technical support team performs a proactive role in familiarizing grantees with the new software and encouraging its use.

NOTE: FY 2001 data consisted of a very uneven mixture of data reported via the old system for the first half of the year with RHYMIS-LITE data reported from April onward after OMB approved the new information collection. During the remainder of FY 2001, grantees received, installed, trained, and operated the new software. In its biennial FY 2000-2001 report to Congress, mandated by the 1999 Runaway and Homeless Youth Act (as reauthorized), FYSB did not report any RHYMIS or partial RHYMIS-LITE data prior to FY 2002, but described the program improvement activities.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

POSITIVE YOUTH DEVELOPMENT OUTCOME I: Runaway and homeless youth and pregnant and parenting teens find safety, shelter and services that support their well-being and development into adults.

PROGRAM GOAL I: Provide appropriate shelter, counseling and other support services to youth and their families in high-risk situations.

6.4a. FY 2003: *Increase to X+y percent the proportion of youth living in safe and appropriate settings after exiting ACF-funded services.*

FY 2004: *Increase to X+y percent the proportion of youth living in safe and appropriate settings after exiting ACF-funded services.*

Data Source: RHYMIS-LITE

This measure will have a revised FY 2003 baseline, based on FY 2002 data from the new instrument.

YOUTH DEVELOPMENT OUTCOME II: Youth have relationships with and increasing trust for caring, capable adults.

PROGRAM GOAL II.A: Prevent or mitigate severe youth crises by maintaining the credibility of RHY services among youth, increasing the level of trust which youth feel for service providers, and by publicizing opportunities to receive help (such as from the National Runaway Switchboard or local youth agencies) before situations deteriorate and/or the youth leaves home (revised goal statement).

6.4b. FY 2003: *Increase to the proportion of youth that call the National Runaway Switchboard when they are contemplating running away (but before they do so). (Dropped)*

Data Source: National Runaway Switchboard

This measure has been dropped because of the difficulty of tracking the intention and timing of the contact.

Developmental Measure:

6.4c. FY 2003: *Maintain the proportion of youth that contact the National Runaway Switchboard (for counseling and referral to safe shelter or other services) earlier rather than later in their runaway episode (up to the first week). (Developmental)*

FY 2004: Maintain the proportion of youth that contact the National Runaway Switchboard (for counseling and referral to safe shelter or other services) earlier rather than later in their runaway episode (up to the first week). (Developmental)

POSITIVE YOUTH DEVELOPMENT OUTCOME III: Youth are empowered to develop into independent, contributing members of society.

PROGRAM GOAL III.A: Increase the involvement of youth in service to their communities.

Developmental Measure

6.4d. *FY 2003: Establish and maintain the number of BC and TLP youth engaged in activities that help others or the community through community service and service learning.*

FY 2004: Maintain the number of BC and TLP youth engaged in activities that help others or the community through community service and service learning.

Data Source: RHYMIS-LITE

PROGRAM GOAL III.B: Strengthen youth in reaching their full potential socially and economically by providing opportunities that move them toward self-sufficiency.

Developmental Measure

6.4f. *FY 2003: Increase the number of youth in the transitional living programs who successfully complete the program.*

FY 2004: Increase the number of youth in the transitional living programs who successfully complete the program.

Data Source: RHYMIS-LITE

PROGRAM GOAL III.C: Build partnerships across governments, with communities, and with youth to help youth develop as individuals and as citizens.

6.4g. *FY 2003: Maintain at 13 States and youth services grantees in those States a collaboration that supports a youth development approach to services for young people, including substance abuse and teen pregnancy prevention activities and add additional States as resources become available. (Dropped)*

This measure is being dropped since it will no longer have meaning as the current group of States completes its term. FYSB is helping grantees conduct evaluations of these projects. Evaluations will be published in FY 2003 or early the following year.

POSITIVE YOUTH DEVELOPMENT OUTCOME IV: Youth achieve good mental and physical health and a greater sense of optimism, empowerment and possibility.

PROGRAM GOAL IV: Build on the strengths of long-term residential programs to provide skills, produce confidence and achieve lasting benefits in the lives of youth transitioning to adulthood.

Developmental Measures

- 6.4h. FY 2004: Increase the number of youth in Transitional Living Programs who are provided tools, training, and experiences to feel prepared for life as measured by youth who complete high school/GED, receive skills or job readiness training, and/or secure employment.**

Data Source: RHYMIS-LITE

6.5 TEMPORARY ASSISTANCE FOR NEEDY FAMILIES: CHILD WELL-BEING

Program Purpose and Legislative Intent

The purposes of TANF are to provide assistance to needy families so that children can be cared for in their own homes; to reduce dependency by promoting job readiness, work and marriage; to prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. TANF is authorized under title IV-A of the Social Security Act, as amended by PRWORA. (A detailed discussion of TANF has been provided under Strategic Goal 1.)

Under the President's welfare reauthorization proposal, child well-being would become an explicit goal of TANF and funding would be available to support demonstration and research projects aimed at improving child well-being through the promotion of healthy marriages and family formation.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Enhance child well-being by promoting healthy marriages and family formation and reducing out-of-wedlock pregnancies.			
6.5a. The number of States implementing initiatives to promote healthy marriages. (Developmental)	FY 04: NA	FY 04: (baseline)	Px 122

PROGRAM DESCRIPTION AND CONTEXT

ACF uses TANF resources to develop strategies aimed at promoting healthy marriages and family formation. For example, a majority of States have eliminated restrictions on two-parent families' eligibility for welfare, such as the requirements under the previous AFDC program that one parent be either incapacitated or unemployed. Several States have undertaken efforts to promote healthy marriages ranging from pilot programs to statewide initiatives. ACF is providing technical assistance and conducting research projects to further knowledge about how strengthening marriage can promote child well-being.

PROGRAM PERFORMANCE ANALYSIS

ACF has established this new objective because of the strong indication that there is a significant relationship between family structure and child well-being. Research indicates that children who grow up in healthy, married, two-parent households have a more solid foundation for success. They are less likely to experience poverty, engage in high-risk behavior, or suffer from emotional or developmental problems. Over time, these children have higher levels of educational attainment, employment opportunity and earning potential. In contrast, children who grow up in non-married households or without their father present, are more likely to live in poverty, drop out or fail out of school, engage in at-risk behavior and suffer emotional or psychological problems necessitating treatment.

Performance Report

ACF will begin reporting on State activities that promote healthy marriages and family formation initiated in FY 2004. This information will produce baseline data for this process measure.

Data Issues

Lack of data represent one of the main limitations in research relating to marriage and family formation. Specifically, few data exist at the national or State level that allow researchers to track marriage, divorce and related issues. ACF will address these limitations by working with States and other partners in developing or enhancing data collections systems to capture marriage-related information and facilitate future research.

Performance Plan

Performance Measures for FY 2004

PROGRAM GOAL: Enhance child well-being by promoting healthy marriages and family formation and reducing out-of-wedlock pregnancies.

Developmental Measures

6.5a *FY 2004: The number of States implementing initiatives to promote healthy marriages. (Developmental)*

Data Source: TANF Administrative Data

This measure has been added as a process measure to assess the number of States implementing marriage promotion activities under TANF. ACF expects to enhance this measure to assess the breadth of marriage promotion activities at the State level under TANF and eventually to replace this process measure with an outcome-oriented measure which will measure the well-being of children in healthy marriages among low-income married couples.

STRATEGIC GOAL 3: INCREASE THE HEALTH AND PROSPERITY OF COMMUNITIES AND TRIBES

RATIONALE

Strong neighborhoods and communities provide positive, healthy environments for children and families. ACF achieves its goal of increasing the health and prosperity of communities and Tribes by strengthening local community partnerships, improving civic participation, and working with Tribes and Native American communities to build capacity and infrastructure for social and economic development.

ACF supports a variety of activities in its community-based programs. These include strategies to create jobs in economically disadvantaged communities, to help communities develop comprehensive service networks for supporting local residents, to empower residents to leverage local assets and to assist communities in their efforts to respond to energy emergencies and to prevent family violence.

The LIHEAP request for an increase of \$300 million over the FY 2003 President's Budget will enable States to meet energy emergencies of our most vulnerable populations (the elderly, households with small children and persons with disabilities) due to extremes in temperature, either during severe cold weather in the winter or sustained heat waves in the summer. The request for an increase of \$843,000 for the Domestic Violence Hotline will assure adequate responsiveness to increased calls due to public awareness messages.

OBJECTIVES AND MAJOR PROGRAM AREAS

7. *Build healthy, safe and supportive communities and Tribes*

Community Services Block Grant
Family Violence Prevention Program
Low-Income Home Energy Assistance
Native Americans Programs

7. **BUILD HEALTHY, SAFE AND SUPPORTIVE COMMUNITIES AND TRIBES**

Approach for the Strategic Objective: Strengthen local communities through community partnerships and improving civic participation; increase community development investments so that families can lead healthy, safe and productive lives; and work with Tribes and Native American communities to develop strategies and programs to promote social and economic development and self-sufficiency.

The Secretary of HHS created a Rural Task Force to examine how HHS programs can be strengthened to better serve rural communities. ACF supports that effort and has identified strengthening rural families and communities as one of its key priorities. Additionally, ACF is working with the Office of the Secretary and other HHS Operating Divisions (OpDivs) -- particularly Health Resources and Services Administration (HRSA) -- to ensure that the

Secretary's Rural Initiative Task Force gives appropriate attention to human services policy and program matters. Among other activities, ACF will support the new HHS Advisory Committee on Rural Health and Human Services by providing information for a Department-wide clearinghouse on rural issues, exploring the possibility of using geographic information system technology for agency-wide planning on rural issues, and assisting HRSA in its' implementation of State-wide and local-level demonstration projects to provide human services and health services in rural areas.

7.1 COMMUNITY SERVICES BLOCK GRANT

Program Purpose and Legislative Intent

The purpose of the Community Services Block Grant (CSBG) Program is to assist States and local communities to reduce poverty, revitalize low-income communities and empower low-income families and individuals to become more self-sufficient. Ninety percent of the CSBG funds pass through States to local eligible entities, most of which are Community Action Agencies (CAAs). Based on local needs assessment, local agencies use CSBG funds to leverage resources to coordinate and develop programs filling gaps in their community service system with a wide variety of programs, services and activities.

CSBG provides the core funding to communities to develop the capacity to ameliorate the conditions and causes of poverty. State and local agencies supplement the resources of the CSBG through volunteers and other financial resources in order to carry out the many activities required to reduce poverty. Therefore, an important measure of the capacity of States and local CSBG service providers to carry out this program is whether they are successfully building the capacity to leverage resources to provide needed services and activities.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Ensure that low-income people have a stake in their community.			
7.1a. Increase by two percent over the previous year the number of volunteer hours contributed by CSBG consumers in one or more community groups (in million of hours).	FY 04: Increase 2% FY 03: 30.07 FY 02: 29.48 FY 01: 27.7 FY 00: 28.9 FY 99: 28.6	FY 04: 12/05 FY 03: 12/04 FY 02: 12/03 FY 01: 30.3* FY 00: 30.7 FY 99: 27.46 FY 98: 26.86 FY 97: 27 FY 96: 28.06	Px 130 HHS 6.4
*50 States Reporting			

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Conditions in which low-income people's lives are improved.			
7.1b. Increase by two percent over the previous year the amount of non-Federal resources brought into low-income communities by the Community Services Network (in billions of leveraged non-Federal funds).	FY 04: Increase 2% FY 03: \$1.7 FY 02: \$1.68 FY 01: \$1.66 FY 00: \$1.38 FY 99: \$1.36	FY 04: 12/05 FY 03: 12/04 FY 02: 12/03 FY 01: \$2.5** FY 00: \$1.83 FY 99: \$1.92 FY 98: \$1.64 FY 97: \$1.26 FY 96: \$1.20	Px 130 HHS 6.4
**(5: States Reporting)			
Total Funding (dollars in millions)	FY 04: \$495.0 FY 03: \$570.0 FY 02: \$650.0 FY 01: \$657.7 FY 00: \$584.3 FY 99: \$553.3	Bx: budget just: Section Px: page # performance plan	
See detailed Budget Linkage Table in Part I for line items included in funding totals.			

PROGRAM DESCRIPTION AND CONTEXT

At the heart of CSBG is ROMA – Results Oriented Management and Accountability – that began prior to the passage of GPRA to focus on increasing the capacity of local providers to increase program performance. ROMA is an interagency initiative, which promotes outcome-based management strategies for community, State and Federal programs participating in the CSBG programs. It not only provides the opportunity for States and local agencies to measure results but more importantly, it provides a framework for examining agency mission and goals and evaluating progress for all of the family and community development programs delivered by the Community Action Agencies. The implementation of ROMA is one of the most effective ways for OCS to encourage program improvement in a devolved block grant environment. ROMA measures progress and allows partners at each level – local, State and Federal – to focus on the training and technical assistance required for achieving the six national goals:

- Low-income people become more self-sufficient;
- Conditions in which low-income people live are improved;
- Low-income people own a stake in their community;
- Partnerships among supporters and providers of services to low-income people are achieved;
- Agencies increase their capacity to achieve results; and
- Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other supportive systems.

Funds have been provided to develop and implement cutting-edge management and measurement tools such as (a) scales that measure incremental progress of families and communities; (b) entry-level training in performance measurement and strategic planning; (c) the development of an advanced train-the-trainer program; and (d) innovative data collection tools. OCS worked closely with national, State and local partners to effectively share the findings and products of these efforts.

Flexibility to tailor services and activities to individual family and local community need is the key to any successful delivery system. A major challenge in developing ROMA was to retain the legislatively intended flexibility at the local level while maintaining a tool for national accountability. During this development phase, ROMA allowed localities and States to collaborate on the best incremental measures for their programs while developing a system for aggregating data at the national level.

ROMA has been adopted by a significant portion of the Community Services Network. OCS is in the process of identifying six to ten outcome measures across the six goals that best reflect community action programs. These outcomes will be required of all community action agencies in all States and information will be collected based upon the services of all the programs and services within an agency that contribute to achieving the outcome, not just CSBG. OCS is establishing plans and timetables in collaboration with States and localities to have this additional ROMA requirement in place by Fiscal Year 2004.

Program Partnerships

Given CSBG's anti-poverty focus, the program relies on partnerships at the State and local level to achieve its mission. Crosscutting partnerships enable CSBG to provide its clients with a broad spectrum of activities aimed at ameliorating the causes and conditions of poverty. However, CSBG's programmatic diversity also raises one of the primary challenges to program effectiveness, a challenge that demands continuous attention and nurturing on the part of program staff at all levels.

PROGRAM PERFORMANCE ANALYSIS

The 1998 Reauthorization Act required that by FY 2001 all agencies should begin implementing ROMA. As a response, OCS identified core activities to States to measure ROMA progress. OCS encouraged States and eligible entities to use core ROMA activities to assess their own progress and to identify what work would need to be completed by FY 2003.

States currently engage in several key activity areas: (1) to provide technical assistance in the form of statewide partnership grants for statewide implementation of ROMA; (2) to use five-year grants to strengthen the capacity of State CAA Associations; (3) to assist eligible entities through special State technical assistance grants to address complex issues relating to ROMA implementation; (4) to provide a Train-the-Trainer institute on ROMA; and (5) to provide a National Academy to help agencies build their leadership and financial management capacity.

As indicated, because CSBG provides the core funding in communities used to develop their capacity to ameliorate the conditions and causes of poverty, OCS expects agencies to supplement CSBG resources through volunteers and other leveraged financial resources. Therefore, States must be successful in filling the gaps for services and activities. OCS also holds CAAs accountable for achieving two of the key national goals:

- The extent to which local residents volunteer to work with the CSBG-supported agencies; and
- The extent to which Community Action Agencies are able to "leverage" funds from other programs to enhance their efforts to achieve one or more of the six national CSBG goals.

The first measure – the number of hours of volunteer work contributed by the community residents – reflects how well the local Community Action Agency has engaged its target population and community, and the degree to which its programs reflect community needs and interests. This connection with the community distinguishes CSBG from other programs focused on anti-poverty and economic development work.

The second measure – the amount of non-Federal funds leveraged by Community Action Agencies – points to three key attributes. First, it reflects the willingness of other State, local and private partners to collaborate and to invest in the agencies. Second, it recognizes that the broader goals of self-sufficiency and community economic development require strong partnerships across public, private and non-profit sectors of the community. Third, it acknowledges that CSBG cannot support all the work of community action, but plays a critical role in partnership development.

Performance Report

CSBG networks have achieved consistently high levels of volunteer contributions (measure 7.1a). However, the contributions have fluctuated over the last several years, declining from a high of 28 million hours in 1996 to 26.8 million hours in 1998 and then rising from 27.4 million hours in 1999 to 30.3 million hours in 2001. This increase is 2.6 million above the FY 2001 projected target. ACF expects that the volunteer contribution will continue to increase as agencies develop new volunteer opportunities. Pilots have been initiated in several States to address volunteerism and the populations of the aged and disabled, striving to help seniors and disabled populations obtain public benefits. With the help of faith- and community-based organizations, houses of worship, and youth – and working in partnership with the National Council on the Aging – volunteers will help individuals within these populations to access public benefits.

A four-year (1994-97) trend analysis of local networks' resources revealed that there has been a decline in non-CSBG resources, largely due to the elimination or reduction of Federal funding in discretionary domestic programs for low-income individuals and communities. Many programs, historically administered by CAAs and other community-based organizations, were eliminated while others were drastically reduced. The steady growth in resources in all other sectors kept the network from a precipitous loss of capacity to respond to the needs of the low-income community.

The levels of non-Federal funding consistently increased since FY 1997. The measure (7.1b) identifies non-Federal funds, which increased to \$1.92 billion in 1999 from \$1.20 billion in 1996. In FY 2001, non-Federal funding exceeded the target by \$84 million. This is an increase of \$67 million from the FY 2000 actual because the number of States reporting increased from 49 to 51 in FY 2001. ACF expects that CSBG grantees will continue their efforts to leverage increases in non-Federal funds.

The following table illustrates how ACF is investing FY 2002 resources to improve the efficiency and effectiveness of the Community Services Block Grant Program at the State and community levels.

**BUDGET TABLE LINKING INVESTMENT OF
ACTIVITIES/OUTPUTS/OUTCOMES**

Investments*	Activity	Outputs	Outcomes
\$2,500,000	Training and Technical Assistance	Statewide Partnership Grants and Regional Collaboration	Statewide Implementation of ROMA
\$2,300,000	Develop and Implement Management and Measurement Tools	Ability to Measure Incremental Progress	Strengthen Capacity of State CAA Associations to Implement a Performance Measurement System
\$1,158,000	Develop Advanced Train-the-Trainers Program	Trained Professionals	Increased Training at the Local Level
\$700,000	Develop Data Collection Tools	Improved Data Collection	Accurate, Valid Data Collection System

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

Data collected for CSBG are collected through the CSBG Information System (CSBG/IS) survey, which is administered by the National Association for State Community Services Programs (NASCS). OCS and NASCS have worked closely to ensure that the survey captures the required information. Because the CSBG is a Block Grant and States have flexibility in determining their program years, there is substantial time lag in reporting. NASCS and OCS have worked closely to ensure that reporting by States is more timely and complete by providing better survey tools and reporting processes. Over the past two years, the time lag in reporting has decreased by six months. OCS' goal is to receive CSBG data by the next fiscal year. Technology continues to be a major concern for States and local agencies in providing quality data collection and reporting. However, local agencies, typically non-profit organizations whose

funds are primarily dedicated to and invested in providing service, view developing and investing in technology as a secondary concern. With the need to track outcomes for families and clients over longer periods of time comes the need for more sophisticated tools. Much of the technical assistance provided by OCS and the States in the past several years has focused on assisting States and agencies in meeting this challenge.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Ensure that low-income people have a stake in their community.

7.1a. FY 2003: *Increase by two percent over the previous year the number of volunteer hours contributed by CSBG consumers in one or more community groups.*

FY 2004: *Increase by two percent over the previous year the number of volunteer hours contributed by CSBG consumers in one or more community groups.*

PROGRAM GOAL: Use Federal funds as leverage to improve conditions where low-income people live.

7.1b. FY 2003: *Increase by two percent over the previous year the amount of non-Federal resources brought into low-income communities by the Community Services Network.*

FY 2004: *Increase by two percent over the previous year the amount of non-Federal resources brought into low-income communities by the Community Services Network.*

States and agencies are continuing to develop and test a menu of performance measures that reflect impact on low-income families and communities. In FY 2004, this menu will be refined and consolidated to provide a more detailed picture of the results achieved. Several CSBG partners have begun experimenting with community-level measures, e.g., "increase in affordable housing available" and "increase in the amount of property tax generated as a result of rehabilitation projects." Additional measures will be considered for inclusion in future annual performance plans as the Network gains more experience and sophistication in determining the most appropriate indicators for measuring community revitalization results.

7.2 FAMILY VIOLENCE PREVENTION

Program Purpose and Legislative Intent

The purpose of the Family Violence Prevention and Services Act (FVPSA) is to assist States and Indian Tribes in their efforts to respond to and prevent family violence. ACF's Family Violence

Prevention and Services Program (FVPSP) is responsible for the administration and oversight of a number of activities pertaining to family violence. FVPSA allocates funds to support the provision of immediate shelter and related assistance for victims of family violence and their dependents. Funding is also allocated to carry out coordination, research, training, technical assistance, and clearinghouse activities.

The Family Violence Prevention and Services Act was enacted as title III of the Child Abuse Amendments of 1984, and was reauthorized and amended most recently by the Victims of Trafficking and Violence Protection Act of 2000 (Pub. L. 103-322).

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
<i>PROGRAM GOAL: Build healthy, safe and supportive communities and Tribes that increase the ability of family violence victims to plan for safety.</i>			
<i>Objective: Support programs to provide immediate shelter and related assistance for victims of family violence and their dependents.</i>			
7.2a. Increase the number of Federally recognized Indian Tribes that have family violence prevention programs.	FY 04: 200 FY 03: 195 FY 02: 190 FY 01: 189 FY 00: 174 FY 99: 162	FY 04: FY 03: FY 02: 184 FY 01: 181 FY 00: 187 FY 99: 174 FY 98: 174 FY 96: 120	Px 137
<i>PROGRAM GOAL: Ensure that victims of domestic violence and sexual assault, their family and friends, and others interested in their safety and support, have a source of comprehensive and timely information, crisis services, and assistance.</i>			
7.2b. Increase the capacity of the National Domestic Violence Hotline to respond to an increase in the average number of calls per month.	FY 04:12,500 FY 03:12,000 FY 02:11,500 FY 01:11,000 FY 00: NA FY 99: NA	FY 04: FY 03: FY 02: 12,500 FY 01: 13,800 FY 00: 11,000 FY 99: 11,000 FY 98: 8,000	Px 137
<i>Objective: Build the capacity of the National Domestic Violence Hotline to receive and respond to calls from sexual assault victims/survivors and their family/friends.</i>			

7.2c. Increase the amount of training hours provided to advocates to handle sexual assault calls. (Developmental)	FY 04: 384 FY 03: 192	FY 04: FY 03: FY 02: Baseline	Px 135
Total Funding (dollars in millions)	FY 04: \$127.4 FY 03: \$126.7 FY 02: \$126.7 FY 01: \$119.1 FY 00: \$103.5 FY 99: \$ 90.5	Bx: budget just. section Px: page # performance plan	
See detailed Budget Linkage Table in Part I for line items included in funding totals.			

PROGRAM DESCRIPTION AND CONTEXT

Family violence is a broad term, encompassing all forms of violence within the context of family or intimate relationships, including domestic violence, child abuse and elder abuse. The primary focus of the FVPSA has been supporting intervention and prevention efforts targeting domestic violence, or violence and abuse between adult intimate partners. Most commonly, domestic violence involves the abuse of a female by a male partner or ex-partner, current or former spouse, or date. Domestic violence is an issue of increasing concern because of its far-reaching and negative effects on all family members, including children. Domestic violence is not confined to any one socioeconomic, ethnic, religious, racial, or age group, and occurs in rural, urban and Tribal communities. It is the leading cause of injury to women in the United States, where they are more likely to be assaulted, injured, raped or killed by a male partner than by any other type of assailant.

Statistics show that nearly 30 percent of all violence against women by a single offender is committed by an intimate – a husband (3.4 percent), ex-husband (1.6 percent), boyfriend/ex-boyfriend/well-known-to-victim (24.6 percent). Estimates from the National Crime Victimization Survey (NCVS) indicate that the number of female victims declined from 1993 to 1998. In 1998 women experienced about 900,000 violent offenses at the hands of an intimate, down from 1.1 million in 1993. Estimates from a compilation of data maintained by the Bureau of Justice Statistics and the Federal Bureau of Investigation on violence and reported in March of 1998 showed a similar decline in the number of victimizations experienced by women at the hands of an intimate partner. Data on the rates of intimate partner violence considered by age category indicate that from 1993 to 1998, women ages 16 to 24 experienced the highest per capita rates of intimate partner violence (19.6 per 1,000 women).

Accurate information on the extent of domestic violence is difficult to obtain because of extensive under-reporting. Using the above estimates as evidence of reported incidence, domestic violence experts project that each year in this country between one and four million women are abused to the point of injury by a male partner or ex-partner. About one-fourth of all hospital emergency room visits by women result from domestic assaults.

The National Violence Against Women (NVAW) also reported that rates of intimate partner violence vary significantly among women and men of diverse racial backgrounds. Results from the NVAW Survey in July 2000 indicate that African American and American Indian/Alaska

Native women and men report more violent victimization than do women and men of other racial backgrounds. The survey also found that Asian/Pacific Islander women and men tend to report lower rates of intimate partner violence than do women and men of other minority backgrounds. In response to the NVAW statistical data, several initiatives have been implemented through FVPSA to facilitate and improve its outreach, information gathering, and service response to under-served communities. Such initiatives include the mobilization of researchers, academicians, and practitioners around issues of family violence that affects these particular communities. These efforts have resulted in the development of the Institute on Domestic Violence in the African American Community, the National Symposium on Domestic Violence in the Latino Community, the Women of Color Network, and the Asian American Institute on Domestic Violence.

This violence takes a devastating toll on children who are exposed to its cruelty. Three to four million children witness parental violence every year. Children whose mothers are victims of wife battery are twice as likely to be abused as those children whose mothers are not victims of abuse. When children witness violence in the home, they have been found to suffer many of the symptoms that are experienced by children who are directly abused.

Components of FVPSA are State and Tribal Programs, Discretionary Program and activities, the Domestic Violence Resource Network (DVRNetwork), and the National Domestic Violence Hotline (NDVH).

State and Tribal Programs: The FVPSA State and Tribal grants program authorized by Section 303 of the Family Violence Prevention and Services Act serves as the primary Federal mechanism for encouraging State, Tribal and local support for implementing, maintaining, and expanding programs and projects to prevent family violence. FVPSA funds continue to supplement many already established community-based family violence prevention and services activities. In particular, these funds have been instrumental in promoting and supporting the development of services in rural and other underserved areas.

Discretionary Program and Activities: Each fiscal year, FVPSA discretionary funding supports public agencies and nonprofit organizations in establishing, maintaining, and expanding programs and projects to prevent incidents of family violence and provide immediate shelter and related assistance to victims and their families. Discretionary funding is typically limited to applicants who specify goals and objectives having national and local relevance. Moreover, the programs must demonstrate applicability to the coordination efforts of national, Tribal, State and community-based organizations.

There are more than 1500 domestic violence shelters in the United States that provide emergency shelter and intervention services for victims of domestic violence and their dependents. Shelters vary in size, preferred location, range and scope of services offered to clients, and in physical capacity. Physical capacity may dictate shelter operations and whom they serve. Shelters are not required to serve a set number of programs. However, all domestic violence shelters will provide a core set of services that include: physical shelter for the protection and safety of the victim and children; crisis intervention hotline services; individual and group counseling; and information and referral services.

The Domestic Violence Resource Network (DVRNetwork): The DVRNetwork was established in 1993 as part of the 1992 amendments to the FVPSA. The FVPSP initially provided funding for the development and operation of a National Resource Center on Domestic Violence and three special issue resource centers – the Battered Women’s Justice Project (focusing on civil and criminal justice issues), the Health Resource Center on Domestic Violence, and the Resource Center on Domestic Violence: Child Protection and Child Custody. In 1997, funding was made available to establish a fourth special issue resource center (The Sacred Circle) focusing on the technical assistance and training needs of Tribes and Native American communities.

National Domestic Violence Hotline (NDVH): The NDVH became operational in 1996 as a project of the Texas Council on Family Violence and serves as a critical partner in the prevention and resource assistance efforts of the Domestic Violence Resource Network (DVRNetwork).

The toll-free, 24-hour NDVH provides:

- Crisis intervention to help callers identify problems and possible solutions, including development of emergency safety plans;
- Information about sources of assistance for individuals and their families, friends, and employers wanting to learn more about domestic violence, child abuse, sexual assault, intervention programs for batterers, criminal and civil justice system issues, and other critical concerns; and
- Referrals to battered women’s shelters and programs, social services agencies, legal programs, and other groups and organizations willing to help.

The Hotline is committed to meeting the needs of diverse communities and provides bilingual Spanish-English staff, text telephones for callers who are hearing impaired, access to translators in 139 languages, and materials in a variety of languages and formats.

Program Partnerships

ACF recognizes that coordination and collaboration at the local level among the police, prosecutors, the courts, victim services providers, child welfare and family preservation services, TANF agencies, and medical and mental health providers facilitate a more responsive network of protection and support for families dealing with domestic violence. To help develop a more comprehensive and integrated services delivery approach, HHS urges State agencies and Indian Tribes receiving funds under FVPSA to coordinate planning activities with new and existing State, local, and private sector agencies.

State Domestic Violence Coalitions: The FVPSP administers grants to statewide private nonprofit domestic violence coalitions to conduct activities that promote domestic violence prevention and intervention and the increase in public awareness of domestic violence issues. Needs assessment and planning activities conducted by coalitions are designed to document gaps in current response and prevention efforts and help guide future endeavors. FVPSA funding also enables State coalitions to provide technical assistance to State agencies and organizations on

policy and practice related to domestic violence intervention and prevention, as well as ongoing training and support to local domestic violence programs, many of whom receive State allocated FVPSA funds.

PROGRAM PERFORMANCE ANALYSIS

With each amendment of the legislation, the FVPSA responsibilities have grown. In addition to overseeing State and Tribal activities, the FVPSA administers grant programs for State domestic violence coalitions carrying out technical assistance, training and prevention efforts. Moreover, the FVPSA provides ongoing support for the Domestic Violence Resource Network, which now includes the National Resource Center on Domestic Violence, four special issue resource centers, and the National Domestic Violence Hotline.

The National Domestic Violence Hotline (Hotline) is a significant entity in facilitating victims' access to shelter and services. The Hotline answered more than 720,000 calls since the inception in February 1996. Each year the number of calls to the Hotline have increased in addition to the number of calls responded to by the Hotline advocates. Hotline staff and volunteers provide victims of domestic violence and those calling on their behalf with crisis intervention, information about domestic violence and referrals to local service providers. The services of the Hotline are available 24 hours a day, seven days a week and not one day of service has been missed. One call to the Hotline summons help in English or Spanish. Hotline staff and volunteers have access to translators in 139 languages. The Hotline data collection program collects, analyzes and disseminates national data on the nature, scope and impact of family violence in the United States for professionals and policy makers at the local, State and national levels. This data on Hotline callers has not been available before. Assistance through e-mail is available at ndvh@ndvh.org.

Performance Report

During the past decade, there has been an expansion in the number of grants to Indian Tribes for preventing family violence. The FVPSA programs on Tribal trust lands and reservations are in the process of evolving towards a more stable and comprehensive set of activities. In FY 2002, the target for measure 7.1a, increasing the number of Federally recognized Indian Tribes that have family violence prevention programs, was not attained. Staff turnover and failure to submit applications by eight Alaskan Native Villages negatively affected this measure. As a result, the Alaskan Native Villages will receive increased attention.

There are several activities underway in an attempt to improve Tribal reporting of family violence intervention and prevention activities. ACF now has the assistance of a newly-funded resource center, Sacred Circle, providing comprehensive technical assistance, support and training to Tribes, Native American communities, and advocates working with Indian women. Sacred Circle has begun working directly with Tribes receiving FVPSA grants both in the collection of data for reporting purposes and to assist them in administering their programs.

Measure 7.1b: In FY 2001, the National Domestic Violence Hotline's capacity to receive and respond to calls was expanded due to a one-time grant from a corporate contributor. This resulted

in exceeding the projected target by 2,800 calls. In FY 2002, the Hotline responded to 12,500 calls, 1,000 more than projected.

Additional funding enabled the NDVH to provide responses to sexual assault as well as domestic violence calls. As a result, measure 7.2c was added to track the increased amount of training hours needed for advocates to handle these sexual assault calls.

BUDGET TABLE LINKING INVESTMENTS TO ACTIVITIES/OUTPUTS/OUTCOMES

Investments*	Activity	Outputs	Outcomes
\$501,213	Training and Technical Assistance	Number of FVPSA grants to Tribes	Increased participation in FVPSA programs by Tribes and Tribal Organizations
\$107,850	Training and Technical Assistance	Increased number of calls responded to by the Hotline	Improved response to domestic violence by Hotline advocates
\$107,850	Training and Technical Assistance	Improved ability to identify cases of sexual assault	Improved response to sexual assault by Hotline advocates

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

Through the Documenting Our Work project the family violence program has initiated several efforts designed to assist in developing performance indicators and outcome measures for the various programs and activities supported with FVPSA funds. This activity is currently being piloted in several States. There is currently considerable variation in the type and comparability of program information and data reported by State and Tribal grantees, State coalitions and discretionary grantees. This is due in part to the variation in services and activities funded within each State or locality, given other Federal, State and local funding that might be available, as well as the varying reporting capacity and requirements of grantees to provide extensive data. This FVPSA effort require collaboration with the States, State domestic violence coalitions, the national resource center network, and Federal-level partners to reach consensus.

Support for the Documenting Our Work project is provided by the National Resource Center on Domestic Violence (NRC). The NRC formed a working group and completed an extensive number of focus group conference calls to assist in building common, but sufficiently inclusive, definitions of the "services" provided by local domestic violence programs. Representatives of the State domestic violence coalitions are participating in the focus groups and initiating a review of the current data elements reported by States and shelters to identify baseline elements.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

The following program performance goals have been developed in two program areas where sufficient data is available to track performance: Tribal program development and the National Domestic Violence Hotline.

PROGRAM GOAL: Build healthy, safe and supportive communities and Tribes that increase the ability of family violence victims to plan for their safety.

Objective: Support programs to provide immediate shelter and related assistance for victims of family violence and their dependents.

7.2a *FY 2003: Increase to 195 the number of Federally recognized Indian Tribes that have family violence prevention programs.*

FY 2004: Increase to 200 the number of Federally recognized Indian Tribes that have family violence prevention programs.

The FVPSA program will provide technical assistance and information to 25 percent of the States and 10 percent of the Indian Tribes aimed at increasing the number of Indian Tribes that sponsor family violence prevention programs. A collaborative effort among the national resource center network and selected State domestic violence coalitions will sponsor the technical assistance activity for States and Tribes as an ongoing activity for this initiative.

Program Goal: Ensure that victims of domestic violence and sexual assault, their families and friends, and others interested in their safety and support, have a source of comprehensive and timely information, crisis information, services and assistance.

7.2b *FY 2003: Increase the capacity of the National Domestic Violence Hotline to respond to an average of 12,000 calls per month.*

FY 2004: Increase the capacity of the National Domestic Violence Hotline to respond to an average of 12,500 calls per month.

The largest challenge to the Hotline is staffing. To adequately respond to 12,000 calls per month requires 26 full- and part-time advocates, 20 relief advocates and 30 volunteer advocates. Staff resources are constrained by factors that inhibit all labor-intensive activities, such as turnovers, work schedules, compensation, and competition with better paying jobs in the local area of the Hotline operation.

Program Objective: Build the capacity of the National Domestic Violence Hotline to respond to calls from sexual assault victims/survivors and their family/friends.

Developmental Measure

7.2c *FY 2003: Increase the amount of training hours provided to advocates to handle sexual assault calls.*

FY 2004: Increase the amount of training hours provided to advocates to handle sexual assault calls.

ACF has found that with additional training in "active listening," the advocates are better able to recognize the sexual assault calls. ACF will provide additional training during FY 2004 to the advocates to provide them with a more structured manner and basis to respond to the calls. ACF anticipates 384 hours of training for the advocates in this effort.

7.3 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

Program Purpose and Legislative Intent

The purpose of the Low Income Home Energy Assistance Program (LIHEAP) is to assist low-income households that pay a high proportion of household income for home energy to meet their immediate home energy needs. States, Federally or State-recognized Indian Tribes/Tribal organizations, and Insular Areas receive Federal LIHEAP block grants to administer the program at the community level.

LIHEAP's legislative intent is to ensure that LIHEAP benefits are targeted to those low-income households with the highest energy costs or needs, taking into account family size. The LIHEAP statute identifies two priority groups of low-income households needing energy assistance:

- **Vulnerable Households:** Households with frail older individuals, individuals with disabilities, or very young children that meet LIHEAP income-eligibility standards.
- **High Energy-Burden Households:** Households with the lowest incomes and highest home energy costs.

REACH: The Human Services Amendments of 1994 (Pub. L. 103-252) added Section 2607B(b) to the LIHEAP statute to establish the Residential Energy Assistance Challenge Option Program (REACH) funded for the first time in FY 1996. REACH awards are used to implement innovative plans through local community-based agencies to help LIHEAP-eligible households reduce their energy vulnerability. The purpose of REACH is to minimize the health and safety risks that result from high energy burdens on low-income Americans; to prevent homelessness as a result of inability to pay energy bills; to increase the efficiency of energy usage by low-income families; and to target energy assistance to individuals who are most in need.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Increase the availability of LIHEAP fuel assistance to vulnerable and high energy burden households whose health and/or safety is endangered by living in a home without sufficient heating or cooling.			
7.3a. Increase the targeting index of LIHEAP elderly households.	FY 04: 92 FY 03: 91 FY 02: 90:64	FY 04: 11/04 FY 03: 11/03 FY 02: 90:64 FY 01: 90:64	Px 145 HHS 6.1
7.3b. Increase the targeting index of LIHEAP young child households.	FY 04: 110 FY 03: 109 FY 02: 109:64	FY 04: 11/04 FY 03: 11/03 FY 02: 109:64 FY 01: 108:64	Px 145 HHS 6.1
In FY 2001-2002, the target was expressed as a comparison of vulnerable household to eligible but non-vulnerable households. FY 01 and FY 02 targeting indices are baseline data. In FY 2003-2004, a targeting index of 100 for a specific group of households indicates that group's representation in the LIHEAP recipient population is the same as that group's representation in the LIHEAP eligible population. A targeting index below or above 100 indicates a lower or higher representation rate for a recipient population group. Elderly households are those LIHEAP eligible households having at least one member 60 years or older. Young child households are those LIHEAP eligible households having at least one member five years or younger.			
7.3c. Increase the targeting index of LIHEAP recipient high-energy-burden households compared to LIHEAP recipient low-energy-burden households.	FY 03: Dropped FY 02: NA		
Total Funding (dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$2000.0 FY 03: \$1700.0 FY 02: \$2000.0 FY 01: \$1855.7 FY 00: \$1844.4 FY 99: \$1275.3	Bx: budget just. section Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

OCS has a limited role in determining how LIHEAP block grant funds are spent. LIHEAP grantees have the flexibility to determine how to implement or target their programs and how best to carry out the purposes of LIHEAP. Grantees can spend LIHEAP funds on the following types of benefits for eligible low-income households:

- Heating or cooling assistance (i.e., fuel subsidies) for recipients to increase the affordability of heating or cooling their homes;

- Energy crisis intervention to assist recipients to cope with weather-related and supply-shortage home energy emergencies, and other household energy-related emergencies; and
- Low-cost residential weatherization and other energy-related home repairs.

Although the LIHEAP statute requires grantees to conduct outreach services, OCS cannot prescribe how such services are delivered. However, OCS can improve the program's performance by making more vulnerable households and high energy burden households aware of LIHEAP benefits. Given that such households have a high need for energy assistance, OCS is initiating a Federal LIHEAP outreach effort to reach more of these households. OCS will assess whether its Federal outreach effort is an effective way to improve program performance in serving vulnerable households. OCS' underlying assumption is that increased program participation by vulnerable households will contribute to the ACF strategic goal of building healthy, safe and supportive communities and Tribes.

OCS will use the following resources, activities, and strategies in initiating its LIHEAP targeted outreach project:

- Develop a generic LIHEAP brochure that includes information that relates health and safety issues to vulnerable and high energy-burden households' need for energy assistance;
- Collaborate with key Federal agencies that assist vulnerable low-income households in disseminating OCS' LIHEAP outreach brochure through their community-based programs;
- Develop an indicator to measure LIHEAP targeting performance to vulnerable and high energy burden households that can be used to compare these households to other eligible households;
- Collect data needed to measure LIHEAP targeting performance to vulnerable, high energy burden and other eligible households;
- Analyze the results of LIHEAP targeting performance to vulnerable and high energy burden households; and
- Use targeting performance results to manage further OCS LIHEAP outreach efforts.

REACH: The REACH program is designed to provide services through local community-based organizations (CBO) to help LIHEAP eligible households reduce their energy vulnerability. The States, Tribes, Tribal Organizations and certain Insular Areas are funded to implement innovative initiatives designed to provide for: a reduction in energy costs on participating households over one or more fiscal years; an increase in regularity of home energy bill payments; and an increase in energy vendor contributions towards reducing energy burdens of eligible households. Energy affordability in the 68 grants, funded for \$35.7 million between 1996 and 2001, has been addressed through aggregation, family development, energy education, and collaboration and negotiation. OCS ensures that targeting is geared to the eligible households through its various communication channels including print and electronic media, and its network of technical support provided at conferences, and one-to-one meetings.

Program Partnerships

Partnerships at the Federal level are key to assuring OCS' LIHEAP outreach information reaches the community level. Beginning in FY 2003, OCS will disseminate its LIHEAP outreach

brochure through the community-based networks of the Administration on Aging for elderly households, Head Start for young children, and the Administration on Developmental Disabilities for persons with disabilities. Additional Federal programs that serve vulnerable households will be included in the dissemination process during FY 2003 and FY 2004.

OCS will build on its partnerships with national organizations and Federal programs in support of its targeted outreach project. Existing partnerships include the following:

- **The National Energy Assistance Directors' Association (NEADA):** The Association has worked closely with OCS on LIHEAP performance measurement and can provide OCS with feedback from State LIHEAP programs on the OCS' outreach project. In addition, NEADA has embarked on its own LIHEAP outreach campaign.
- **OCS Community Services Block Grant Program (CSBG):** This program delivers a range of community-based services to low-income individuals through Community Action Agencies. These agencies serve low-income vulnerable households through various Federal funds. In addition, the LIHEAP statute requires LIHEAP grantees to conduct outreach activities to assure that eligible households are made aware of any similar energy-related assistance available under CSBG.
- **The Department of Energy (DOE) Low-Income Weatherization Assistance Program (WAP):** This program is mandated to target vulnerable households.

REACH: REACH grantees are encouraged to form linkages and partnerships with participating CBOs, utilities, and other agencies to leverage additional resources. REACH is also encouraging its grantees to seek additional resources from the Department of Agriculture's Rural Partnership Office, Rural Development Fund, Department of Housing and Urban Development, Department of Energy, Department of Labor and others. REACH funds can be used creatively in energy-related endeavors to identify and maximize resources for the program.

PROGRAM PERFORMANCE ANALYSIS

LIHEAP grantees are required by law to conduct outreach activities designed to assure that eligible households, especially households with at least one member who is frail elderly, disabled, or a young child, and households with high home energy burdens, are made aware of LIHEAP assistance. However, LIHEAP is not an entitlement program. Approximately 3.9 million households received heating assistance in FY 2001 representing about 13 percent of all households with incomes under the Federal maximum LIHEAP income standard (29.9 million households).

Of the 3.9 million households receiving heating assistance in FY 2001, approximately 1.4 million of these households contained at least one member 60 years or older. Approximately one million of these households contained at least one child five years or younger. Some of these households contained both an elderly person and a young child.

LIHEAP's targeting index is a proxy measure for health and safety outcomes. Improving targeting performance for eligible vulnerable households can help such households avoid serious health risks if they cannot afford to adequately heat or cool their homes. Health risks can include

death from hypothermia or hyperthermia and increased susceptibility to other health conditions such as strokes and heart attacks. Improved targeting performance for eligible high-energy-burden households can help such households avoid safety risks in their homes if they cannot afford to adequately heat or cool their homes. Safety risks can include use of makeshift heating sources or inoperative/faulty heating or cooling equipment that can lead to fires or asphyxiation.

OCS completed its LIHEAP outreach brochure in November 2002, and printed approximately 50,000 copies of the brochure. OCS has held preliminary discussions with the Administration on Aging, Head Start, and the Administration on Developmental Disabilities about their interest and ability to disseminate the LIHEAP outreach brochure for the FY 2003 winter season. The three agencies agreed to assist in OCS' LIHEAP outreach effort.

To quantify LIHEAP targeting performance, OCS has developed a **targeting index** as a performance indicator. The targeting index for a specific group of households is computed by dividing the percent of the assisted target group within the LIHEAP recipient population by the percent of the eligible target group within the LIHEAP eligible population. For example, if 25 percent of the assisted households are elderly households, but eligible elderly households represent 40 percent of the eligible population, the targeting index for eligible elderly households is 63 (100 times 25 divided by 40). This would indicate that eligible elderly households are served at a 37 percent lower rate than they are represented in the eligible population.

A targeting index of 100 for a specific group of households indicates that group's representation in the LIHEAP recipient population is the same as that group's representation in the LIHEAP eligible population. A targeting index below or above 100 indicates a lower or higher representation rate for a recipient population group.

OCS collects data from the Bureau of the Census's annual March Current Population Survey (CPS) on vulnerable households and the receipt of energy assistance. OCS also has collected data from the Department of Energy's 2001 Residential Energy Consumption Survey (RECS) on high energy burden households and the receipt of energy assistance. (RECS is conducted every four years).

Calculating the targeting indexes of elderly and young child (vulnerable) households are based on weighted estimates obtained from the March CPS. The most recent data available are from the March 2002 CPS. OCS will analyze the targeting indexes for vulnerable households by Census division to identify those Census divisions where eligible vulnerable households are underserved. (targeting indexes are not calculated for households with a disabled member as States define disability differently.)

For those vulnerable households that are under-served in particular Census divisions, OCS plans to have its LIHEAP outreach brochures distributed to clients of the local programs funded by Head Start, the Administration on Developmental Disabilities, and the Administration on Aging during the FY 2003 winter season. For other parts of the country, the brochures will be distributed only to program staff of the three federal programs. OCS hypothesizes that the greatest increases in targeting performance can be realized through the targeting of outreach

information to those areas of the country in which targeted households are under-served (measures 7.3a and 7.3b).

OCS is unable to measure LIHEAP targeting of high-energy-burden households beyond FY 2001 (measure 7.3c). Funds were unavailable for OCS to do a follow-up survey in FY 2002 with the sample of LIHEAP recipient households that were included in the 2001 RECS. Consequently, this measure has been dropped for FY 2003. Instead, OCS is planning to conduct an evaluation study in FY 2003 to determine whether the LIHEAP program is targeting eligible high energy burden households. The study will use weighted data from the 2001 RECS.

REACH: REACH programs' performance in reaching their goals are supported through careful targeting of LIHEAP eligible households, reporting out conferences and by publishing lessons learned. Programs are reviewed by independent evaluators and results reported through various media. Evaluation reports have been completed for the first two cycles and their findings have contributed to subsequent program announcements and action transmittals. Programs have been encouraged to demonstrate better targeting, seek other resources that can contribute to addressing and remedying causes of the lack of affordable energy, and to seek new ways and alternative energy sources for addressing the energy problem for this population.

Performance Report

The FY 2001 winter season serves as the baseline in which there was no federal LIHEAP outreach. The FY 2002 winter season served as extended baseline in which there also was no federal LIHEAP outreach. Instead, OCS sent LIHEAP grantees a LIHEAP Information Memorandum in November 2001, reminding grantees of the statutory requirement to target LIHEAP benefits to eligible vulnerable households and eligible high-energy burden households. The targeting index for LIHEAP elderly households remained the same (90) for FY 2001 and FY 2002. However, the targeting index for LIHEAP young households increased from 108 to 109. It is unclear as to what accounts for this increase. This result will need to be taken into account in determining whether LIHEAP targeting performance improves for the FY 2003 winter, as a result of federal targeting of LIHEAP information.

State LIHEAP grantees report annually on the number of LIHEAP-assisted households with at least one member who is elderly, disabled, or five years of age or younger. The following table shows the percent of assisted households nationally for FY 1999-2001 that included elderly members or young children. The variability in the data from one year to the next will need to be taken into account in measuring LIHEAP targeting performance.

PERCENT OF LIHEAP HEATING ASSISTED HOUSEHOLDS CONTAINING AT LEAST ONE ELDERLY MEMBER OR YOUNG CHILD, AS REPORTED BY STATES (FY 1999-FY 2001)

Type of vulnerable household member	FY 99	FY 00	FY 01	FY 02
Elderly*	33%	35%	32%	July 03
Young children**	33%	25%	23%	July 03

*An elderly member is a person who is 60 years or older.

**A young child is a person who is under six years of age. Data on households with a young child were not as reliable for FY 99 as for subsequent fiscal years due to reporting problems and should be used with caution.

BUDGET TABLE LINKING INVESTMENTS TO ACTIVITIES/OUTPUTS/OUTCOMES

Investments*	Activity	Outputs	Outcomes
\$14,000	Development of brochure	50,000 copies produced and disseminated	Vulnerable households will be made aware of their susceptibility to energy-related health and safety issues and the availability of LIHEAP fuel assistance.
\$5,000	Contractual assistance to OCS on measuring LIHEAP targeting performance, using March CPS and RECS data	LIHEAP targeting indices	Improved targeting indexes in underserved Census divisions for vulnerable households compared to non-vulnerable households
\$10,000	Contractual assistance to OCS on assessing the statistical reliability and validity of targeting indices	Reliability and validity assessment	Determination of whether LIHEAP targeting indexes can be used for managing for results.

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

The LIHEAP targeting indices rely on the use of household survey data. These data present the following problems:

- The reliability of household survey data is subject to sampling and non-sampling errors. Consequently, differences in data from one year to the next, between groups of households, and between sections of the country need to be examined.
- Household survey data on public assistance programs undercount the number of assisted households when compared to State-reported data. Likewise, the number of LIHEAP recipient households is undercounted when compared to aggregate data from the program's *LIHEAP Household Report*. The undercount may bias the March CPS and RECS estimates of the percentage of vulnerable households or high energy burden households that received LIHEAP heating assistance. To check for bias, the March CPS and RECS percentages will be compared against each other and state-reported data from the *LIHEAP Household Report*.

The comparisons will be based on data from the previous fiscal year because finalized data from the *LIHEAP Household Report* are not available until approximately 10 months after the end of the fiscal year. The data comparisons may result in adjustments to the March CPS and RECS data.

- Verification of State-reported data on LIHEAP-recipient households is difficult. There are no federal quality control or audit requirements for data reported in the States' *LIHEAP Household Report*.
- OCS needs to examine the reliability and validity of the targeting indices.
- OCS will need to recalculate the targeting indexes for FY 2001 and FY 2002 so that the data will be comparable with subsequent March CPS data that use weights from the 2000 Decennial Census.

REACH: While the process and program evaluations report data on REACH projects, the need to classify and develop approaches for measuring performance in a more rigorous way is being addressed and will become part of future evaluations and reporting.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Increase the availability of LIHEAP fuel assistance to vulnerable and high energy burden households whose health and/or safety is endangered by living in a home without sufficient heating and cooling.

7.3a. FY 2003: Increase the targeting index of LIHEAP elderly households.

FY 2004: Increase the targeting index of LIHEAP elderly households.

7.3b. FY 2003: Increase the targeting index of LIHEAP young child households.

FY 2004: Increase the targeting index of LIHEAP young child households.

Data Source: Annual March CPS

7.3c. FY 2003: Increase the targeting index of LIHEAP recipient high energy burden households compared to LIHEAP recipient low-energy burden households. (Dropped)

This measure has been dropped due to issues relating to the lack of annual follow-up data from a sample of RECS households.

7.4 NATIVE AMERICAN PROGRAMS

Program Purpose and Legislative Intent

The purpose of the Administration for Native Americans (ANA) discretionary grant programs is to promote social and economic development, language preservation and environmental

enhancement. ANA achieves its mission through grants, training, and technical assistance to eligible Tribes and Native American organizations representing 2.2 million individuals.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
PROGRAM GOAL: Support and encourage the role of Tribal elders in the community; promote efforts to involve elders in work as mentors with youth and children, e.g., teaching culture and language in Head Start and other child care programs.			
7.4a. Increase the number of grants that include elder participation.	FY 04: 98 FY 03: 94 FY 02: 70 FY 01: 65 FY 00: 60 FY 99: 44	FY 04: FY 03: FY 02: 114 FY 01: 88 FY 00: 62 FY 99: 55 FY 98: 52 FY 97: 44	Px 150
PROGRAM GOAL: Increase the provision of training and technical assistance services to the diverse Native American population, with particular emphasis on urban organizations, rural and non-federally recognized Tribes.			
7.4b. Maintain the number of TA visits per year to the diverse Native American population, with emphasis on urban Native organizations, rural & non-federally recognized Tribes.	FY 03: Dropped FY 02: 1500 FY 01: 1500 FY 00: 1450 FY 99: 1400	FY 02: 1562 FY 01: 1515 FY 00: 1450 FY 99: 1450 FY 98: 1190 FY 97: 1014	
PROGRAM GOAL: The number of Tribes and Native American organizations receiving economic development-related services.			
7.4c. The number of Tribes and Native American organizations receiving economic development related services. (Developmental)	FY 04: FY 03: NA	FY 04: FY 03: Baseline	Px 151
Total Funding (dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$45.1 FY 03: \$45.2 FY 02: \$45.8 FY 01: \$46.0 FY 00: \$35.4 FY 99: \$34.9	Bx: budget just. Section Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

Promoting the goal of social and economic self-sufficiency through local self-determination is the cornerstone of ANA's program philosophy. Self-sufficiency is that level of development at which a Native American community can control and internally generate resources to provide for the needs of its members and meet its own economic and social goals. Social and economic underdevelopment is the paramount obstacle to the self-sufficiency of Native American communities and families.

In 1981, ACF collaborated with Tribes and Native communities to develop the innovative Social and Economic Development Strategies (SEDS) program. SEDS is based on the premise that a local community has the primary responsibility for determining its own needs, planning and implementing its own programs, and using its own natural and human resources. In initiating the SEDS approach, ACF developed a framework of three interrelated goals:

- Assist Native American leadership in exercising control over their resources;
- Foster the development of stable, diversified local economies which provide jobs, promote economic well-being, and reduce dependency on social services; and
- Support local access to, and coordination of, programs and services that safeguard the health and well-being of people, essential elements for a thriving and self-sufficient community.

Through this direct grant funding relationship, Tribes and Native communities have created administrative systems to operate their own social and economic programs in much the same way as State and local governments. Support for the unique government to government relationship that exists between Tribal governments and the federal government is reflected in this approach.

ANA faces unique challenges in formulating goals and measuring results. As a discretionary grant program funding projects designed and implemented at the local level, the differences between projects are considerable in terms of size, scope, community goals, and funding levels. Because Tribes and Native American communities set their own goals and priorities, ACF requests objective progress reports throughout the project period of the grant and an objective evaluation report once the grant has ended. This system provides information on goals and measures, but these are unique to the Tribe or community. Each grantee is at different stage of social and economic development. Administrative and organizational capacity varies greatly among grantees, making more difficult the prospect of developing uniform measures.

Many ANA grants are aimed at capacity-building and infrastructure development for Tribes and organizations, particularly through developing legal codes and courts systems and revising existing Tribal constitutions. Capacity-building encompasses not only economic development (creation and expansion of businesses and jobs), but also efforts to create new programs as a result of welfare reform. This emphasis on capacity-building ties into the larger ACF goal to facilitate the changes effected by welfare reform by working together in innovative ways. For both economic and social development, capacity-building and infrastructure development are key factors. ANA will continue to work with its partners to develop meaningful GPRA

measures--within the context of sovereignty--for job creation, economic well-being, and reducing dependency on social services across a diverse mix of project types, Tribes, and Native American organizations.

ANA will launch a new initiative for FY 2003 including a series of economic development forums to be held by the ANA Commissioner for the purpose of consultation, dialog and feedback designed to take economic development in Indian country to the next level. ANA has included a new developmental measure to track this activity.

Program Partnerships

ANA coordinates with all ACF program offices on Native American issues. These offices include Head Start, Office of Community Services (Tribal TANF), and the Child Care Bureau. ANA has provided a leadership role on a number of issues within ACF and throughout the Department including the development of the HHS Tribal Consultation Plan, the Tribal Colleges and Universities Plan, and other initiatives involving Native populations. The HHS Intra-Departmental Council on Native American Affairs (IDCNAA), chaired by the ANA Commissioner, coordinates numerous activities and initiatives with HHS agencies, such as the Indian Health Service (IHS), and external departments such as the Department of Interior (DOI).

PROGRAM PERFORMANCE ANALYSIS

In prior years, ANA funded over 225 competitive grants annually totaling over \$34 million in several grant programs including Social and Economic Development, Environmental Regulatory Enhancement and Native Languages Preservation and Enhancement. ANA's grant award process is highly competitive: approximately one-third of applications received are funded each year. The FY 2001 budget increase provided \$10.6 million to fund an increase in grants under ANA programs. This increase provided funds for 91 additional new grants in FY 2001. This level of funding was sustained for FY 2002.

ANA regularly selects new program goals and priorities. For example, ANA continues to play a key role in the Department's Tribal consultation policy implementation and is the ACF lead organization in implementing the Tribal Colleges/Universities (TCU) Executive Order. Through the TCU effort, ANA provided financial assistance in the form of grants to the colleges and universities. ANA also modified its grant eligibility statement to allow TCUs direct competition for funding in addition to Tribes' eligibility.

ANA's new economic development initiative was developed, in part, to address socioeconomic trends indicating that American Indians have higher unemployment rates than the U.S. population. As reported by the Bureau of Indian Affairs (BIA) 1999 Indian Labor Force Report (most recent data available), unemployment was at 43 percent in 1999 and the poverty level among the 556 Federally recognized Tribes increased to 33 percent. It is important to note that individual Tribal data have consistently indicated higher unemployment rates.

ANA anticipates a complete review and validation of existing ANA performance measures in FY 2003 under the new ANA Commissioner's leadership. ANA began this process in FY 2001

based on quarterly meetings with the national training and technical assistance contract providers.

Performance Report

ANA exceeded its targets for FY 2001 and met all targets for FY 2002 by providing consistent technical assistance and emphasizing the role of Tribal elders in Indian communities. Elders play a key role in Tribal culture by protecting and preserving Tribal cultural heritage, including language, traditions and life ways. They also play a critical role in guiding youth. Increased elder participation (measure 7.4a) occurred due to their inclusion in the native language grants awarded and in various SEDS projects that focus on culture. In 1998, with the addition of the Pacific region, the number of T/TA contractors increased from five to six. New contract performance requirements led all contractors to expand the variety of technical assistance delivery methods they use. In addition to on-site assistance, contractors offer walk-up, worldwide web, telephone, fax, e-mail and other state-of-the-art delivery mechanisms. Other initiatives under consideration include on-line chats and threaded discussions, electronic newsletters, and CD-ROM training programs.

**BUDGET TABLE LINKING INVESTMENTS TO
ACTIVITIES/OUTPUT/OUTCOMES**

Investments*	Activity	Outputs	Outcome
\$5,505,926	Elder Participation	Increase in number of grants with Elder participation	Preserve/protest key role of Elders in Tribal culture
\$378,869	Training and Technical Assistance (T/TA)	Maintain number of On-Site visits	Enhance Quality of Technical Assistance
\$Baseline	Economic Development Projects	Number of Tribes receiving services	Catalyst for positive change to lower unemployment rate

* When integrating budget and performance information, ACF programs were encouraged to focus on primary investments used to accomplish program outcomes. Some ACF programs use mainly training and technical assistance resources, while others factor in total budget figures when measuring program impacts. Investment data presented in this table reflect the most appropriate resource base for the program.

Data Issues

The primary source for data collection on the above performance measures is the Grant Award Tracking and Evaluation System (GATES). The grantee information entered into the GATES system includes a full project description, project periods, award amounts, approved objectives, as well as contact information so reports can be generated based on zip code, type of award and other data variables. Recent developments with the latest generation of GATES allow for better interface with other data collecting software thereby enhancing ANA's ability to design and perform systematic validation surveys of grant proposals regarding: the types of projects and proposed participants, including trends and changes from other periods, potential applicants' use of technology, and training and technical assistance providers' outcomes and delivery levels. It is

ANA's goal to design and implement a comprehensive data management system that will allow ANA to realize the full potential of the data contained in grant applications, funded and unfunded, and grantee Program Progress Reports. This Oracle-based software will be built expressly for ANA's data collection needs and will work with GATES to identify data elements in existing documents. The electronic capture of information will greatly enhance ANA's data collection capabilities.

ANA has developed a strategy that utilizes the data management system described above to validate the data it collects. ANA is currently working with other ACF programs to identify and develop standardized, cross-program measures.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Support and encourage the role of Tribal elders in the community; promote efforts to involve elders as mentors with youth and children, e.g., teaching culture and language in Head Start, other child care programs and adult programs.

7.4a. FY 2003: *Increase to 94 the number of grants that include elder participation from the 1997 baseline level of 44 grants.*

FY 2004: *Increase to 98 the number of grants that include elder participation from the 1997 baseline level of 44 grants.*

Tribal elder involvement was selected as a key measure of program performance because the role of Tribal elders is essential in all aspects of Tribal and community life. Supporting Tribal elders and providing a voice for their concerns has been an important emphasis area. Through the Tribal Elders Initiative, elders meet regularly with ANA/ACF officials and staff. Based on the rate of elders' participation in prior years, ANA expects by FY 2004 to increase elder participation by approximately 10 new grant projects. The funding will expand training and technical assistance and increase grant application rates and awards to Tribes and organizations that have not received assistance in the past.

PROGRAM GOAL: Maintain the provision of training and technical assistance services (T/TA) to the diverse Native American population, with particular emphasis on urban organizations, rural and non-federally recognized tribes.

7.4b. FY 2003: *Maintain at 1,500 the number of technical assistance contacts per year by Tribal T/TA contractors to the diverse Native American population, with particular emphasis on urban Native organizations, rural and non-federally recognized Tribes. (Dropped)*

The training and technical assistance measure is being dropped in FY 2003 and replaced by the developmental measure, 7.4c, to focus on increasing economic development ventures.

Developmental Measure**7.4c. FY 2004: *The number of Tribes and Native American organizations receiving economic development related services.***

From 1979 – 1999, the poverty rate among American Indians climbed from 27 percent to 33 percent, far exceeding the national rate. Unemployment rates are also higher than the U.S. population. All the social health and well-being indicators are lower than other population groups.

Effective strategies for economic development and job creation are critical as Tribes implement the next phase of welfare reform. Native American communities are in varying stages of implementing economic development strategies and building governmental and organization capacity. The ANA Commissioner is planning a series of economic development forums to improve the business capacity of Native American communities. This will include consultation and discussion of successful practices and strategies in the areas of small business, manufacturing and energy development used by successful Native American economic development businesses. Feedback from the Commissioner's forums will help to identify quantifiable measures of success as well as baseline data. ANA grants will provide seed money for building governmental infrastructure and strategic planning skills in economic and business development, as well as for small business "incubator" projects. Data collected for measure 7.4c will allow us to assess the impact of this technical assistance effort and grant award process. Even a small percentage increase in economic development-related services will be considered a success since these incubators tend to be small rather than large scale capital investment projects.

STRATEGIC GOAL 4: MANAGE RESOURCES TO IMPROVE PERFORMANCE

RATIONALE

ACF is committed to being a customer-focused, citizen-centered organization as it provides assistance to America's most vulnerable populations. ACF has reached a critical point in its ability to manage a wide array of discretionary and mandatory programs. It is essential that the organization continue to manage resources to improve performance, provide high quality, cost-effective and efficient services, meet customers' needs and expectations, and use state-of-the-art information technology to improve management and data systems.

The FY 2004 budget request for Federal Administration is \$181.0 million, a net increase of \$7.7 million from the FY 2003 budget. This funding level supports 1,455 FTE, 40 FTE below the level requested in the FY 2003 President's Budget.

ACF continues to use strategic management of human and real capital to accomplish the President's management priorities, such as identifying activities and services that could more efficiently be achieved using outsourcing services; targeting improvements in the financial management performance arena, including reduction of erroneous payments and participation in the Department's unified systems integration project; and directing resources to better manage our e-government activities and expand the e-government services we provide to our clients.

As part of a government-wide effort to strengthen the focus on erroneous payments in programs funded by the Federal Government, the ACF federal administration budget includes \$5 million to be targeted to our efforts in identifying and reducing erroneous payments. Three programs will be the focus of our efforts in FY 2004 – Temporary Assistance for Needy Families, Foster Care, and Head Start.

The President initiated five government-wide reforms in FY 2001 to improve the management of the Federal Government. As part of the President's Management Agenda, ACF is working closely with HHS to implement the following reforms:

- **Strategic Management of Human Capital:** De-layering management levels to streamline organizations and reshaping organizations to meet a standard of excellence.
- **Competitive Sourcing:** Making greater use of performance-based contracts; expanding A-76 competitions and more accurate FAIR Act inventories.
- **Improved Financial Performance:** Achieving "clean" audit opinions throughout government and providing more accurate and timely financial information to secure the best performance and highest measure of accountability.
- **Expanded Electronic Government:** Expanding electronic Government applications and other E-Government services.
- **Budget and Performance Integration:** Making Government results-oriented – guided not by process but by performance. (The discussion of ACF's budget-performance integration is in Part I).

These four objectives guide ACF's implementation of the President's Management Agenda:

8. *Develop and retain a highly skilled, strongly motivated staff*

9. *Streamline ACF organizational layers*

10. *Improve automated data and management systems*

11. *Ensure financial management accountability*

Strategic Management of Human Capital: During the last several years, ACF has included activities in the annual performance plan that address human capital issues. ACF's goal is to achieve a higher standard of excellence through increased emphasis on training staff and by streamlining ACF organizational layers. To implement a more efficient organization that is responsive to the needs of the public, ACF will continue to:

- Reduce the number of reporting layers,
- Decrease the supervisor-to-staff ratio,
- Increase the number of staff in direct service positions through redeployment, and
- Eliminate duplication of services.

ACF's objective to "develop and retain a highly skilled, strongly motivated staff" (Objective 8) has been tracked since FY 2000. In FY 2003, ACF reinstated a FY 1999-2000 measure "to decrease the manager to staff ratio" and added the objective "Streamline ACF organizational layers" (Objective 9).

Other initiatives include using the results of work force planning to realign and/or integrate like programmatic/functional responsibilities. Examples of the consolidated and realigned functions include realigning major research functions into the Office of Planning, Research and Evaluation (OPRE), Tribal TANF from the Office of Community Services (OCS) to the Office of Family Assistance (OFA), and TANF programs and fiscal data collections from OPRE and the Office of Administration to OFA; examining the impact of ACF's regional-headquarters reporting relationships on the efficiency and effectiveness of program operations and service delivery to customers; and increasing internal capacity and contracting services from the private sector. In addition, ACF will develop a succession planning strategy to address dwindling resources and the fact that more than 75 percent of the ACF work force will be eligible for retirement in FY 2006.

Competitive Sourcing: ACF contracts out several major activities to private vendors and the Program Support Center (PSC) within HHS: information technology (IT) help desk support; human resources services (personnel, employee relations, employee assistance and select EEO activities such as investigations, counseling, court reporting services); administrative services (records management, personal property management, mail, transportation, incidental labor, management of employee transit benefits and space management); acquisitions management

(procurements, travel card and purchase card programs); and financial services (in some ACF components, aspects of the grants process, including intake and review of applications).

In order to meet the five percent goal of expanding A-76 competitions set forth by OMB for FY 2002, ACF will continue outsourcing these functions. ACF is also contracting out a significant portion of its administrative support needs eliminating the need to hire the projected 16 FTEs to perform these duties. In addition, ACF is relying heavily on contractor support to accomplish its programmatic responsibilities in FY 2002.

ACF plans to further evaluate its current staffing inventory and for FY 2003, ACF has identified 34 full-time equivalents it plans to directly convert or study for possible outsourcing in the following functional areas: audit resolution, grant closeouts, personnel security clearances, telecommunications, facilities management and additional administrative support. ACF has aligned its competitive sourcing plan with ACF's workforce restructuring plan.

In FY 2004, ACF plans to continue the contractor support that is currently being provided in the areas mentioned above. In addition, ACF will directly convert or study additional functions in the areas of administrative support services, customer services, telecommunications and information technology. ACF will continue to review its inventory for possible outsourcing opportunities.

Improved Financial Performance: ACF added a new objective to measure its efforts to achieve this Presidential management reform – Ensure financial management accountability (Objective 11). Federal agencies' financial statements are audited to reassure the public that those statements fairly and accurately represent the agency's financial condition. A "clean" and timely audit opinion on these statements is essential if decision-makers within the agency and at OMB and Congress are to use this information.

ACF received a "clean" or unqualified opinion from the auditors for FY 1999-2001—a major accomplishment that contributed significantly to the Department's clean audit opinion. Nevertheless, this is only one step, albeit a significant one, toward financial accountability to the public. Although ACF has achieved a clean opinion for three years, improvements to its accounting systems and services are still needed, especially with OMB-required compressed deadlines beginning with the FY 2002 audit cycle. The Reports Consolidation Act of 2000 requires that the Department's FY 2002 audit cycle be completed and its Accountability Report be submitted by February 1, 2003, approximately one month earlier than has been required in previous years.

In order to accomplish this successfully in FY 2002, the Department imposed earlier milestones on its OPDIVs as a pilot for the FY 2001 audit cycle. Over the past year, Departmental financial and accounting officials, the OPDIVs and the auditors have been collaborating on ways to achieve the compressed schedules. Because FY 2001 final performance measurement data were not available until the second or third quarter following the end of the fiscal year, ACF provided FY 2000 data in the FY 2001 audit report. Similarly, ACF will provide FY 2001 data (where available) for the FY 2002 audit report.

ACF has developed an Analytical Review policy that requires a more detailed level of supporting documentation be provided by the Program Support Center (PSC). ACF has communicated this policy to the PSC and has confirmed that the PSC will make its best effort to provide the necessary reports in a timely manner. This is one of several critical elements required for a clean audit opinion. The CFO has alerted ACF Principals that appropriate managers must be available during critical periods in the FY 2002 audit cycle to provide any needed input and clearance of information.

For FY 2004, the audit cycle must be completed by November, more than two months earlier than previous years. ACF is working closely with the Department to meet these increasingly shortened audit deadlines. While ACF is committed to achieving future clean opinions, the abbreviated cycles are creating major resource challenges. To help expand our accounting expertise and support our immediate audit activity needs, ACF recently hired a new accountant.

ACF is working to improve the linkage of financial management systems and data to program performance and results and provide more accurate and timely data to financial/program managers for informed decision-making. ACF continues to play a significant role in the Department's Unified Financial Management System (UFMS) initiative by providing staff resources (via details of staff as well as representation on the UFMS Steering Committee, UFMS Planning and Development Committee and the UFMS Policy Workgroups). ACF will provide the additional funds requested by the Department for full implementation of the UFMS.

The purpose of the UFMS is to achieve economies of scale, eliminate duplication, foster consistency in preparation of HHS financial data and streamline business processes to increase operational efficiencies. ACF anticipates that the UFMS will help ACF access the type of data needed to help managers determine which resources have the greatest positive impact on its client populations. OMB requirements for future quarterly financial statements, accelerated end-of-year reporting, comparative financial reporting, and reports that integrate financial and performance information will provide better financial accountability throughout the Federal Government and to the public.

ACF has completed and submitted to the Department three reports describing the agency's efforts to identify and reduce erroneous payments in the Temporary Assistance for Needy Families (TANF), Head Start (HS), and Foster Care programs. Consistent with ACF's Erroneous Payments Plan—developed in collaboration with officials in the Department, OMB, and specific Program Administrations—ACF embarked on a focused review on single audits (reports) conducted of FY 2001 State-administered TANF and Foster Care programs, and HS grantees, where erroneous payments could be an issue. The three reports highlight the findings of these reviews, as well as the mechanisms the Department and ACF currently have in place to identify, reduce and correct erroneous payments under these and other programs. These include the Single Audit process, reviews of financial data, on-site reviews, OIG reports, and regulations for specific programs. ACF's Erroneous Payments Initiative and existing activities support the Administration's Improving Financial Management Reform Initiative. A Child Care review and report are to be completed by the second quarter of FY 2003.

ACF has undertaken a new initiative to establish a Funds Planning Module that will allow grants and program management staff to forecast (plan) and administer Federal funds through a comprehensive system. This module will permit the planning and tracking of ACF program and S&E funds over several different categories, provide for comprehensive on-demand reporting, and will give managers a useful tool for estimating their fiscal year funding needs and adjusting these over time. It will permit meaningful comparisons of funding plans to actual obligations and add another tool for program managers to assess program performance.

Expanded Electronic Government: The objective to improve Automated Data and Management Systems responds directly to this Presidential management reform (objective 10). ACF has developed unique software to provide a common solution for building its Internet applications. The first use of this software will be to capture, validate and store all information now submitted by grantees or potential grantees using government forms for the Grants Administration Tracking and Evaluation System. This information includes grant applications, funding requests and performance reports. The enhanced process significantly reduces the data-entry burden on ACF grants staff and grantees, expedites the receipt and processing of grants and makes timely up-to-date grant information available for ACF decision-making.

Other ACF applications will employ this software to Internet-enable other program applications, such as the Publications, Requestors and Orders Management Information System (PROMIS), supporting the ACF minority outreach program as well as internal administrative requirements in both the central and regional offices. Additional internal administrative systems will be Internet-enabled. This software ensures that ACF will be able to meet the October 2003 target date of the Government Paperwork Elimination Act. This legislation requires agencies to provide for the optional use and acceptance of electronic documents and signatures, and electronic record-keeping where practicable.

ACF has a major initiative under way for better managing e-government activities. Currently, ACF is upgrading its infrastructure and business practices and is making e-government an integral part of the business processes. Training of ACF staff in efficient and effective use of the Internet and Internet-based applications is being conducted. ACF has more than 100,000 web pages receiving thousands of hits daily from the public. ACF intends to use the Internet more effectively to make its processes more citizen-centered.

ACF is participating with the Department to establish an Enterprise Architecture to bring IT and Business objectives together for reengineering business practices and creating more efficient and effective technology solutions to better serve citizens.

Faith-based and Community Initiative

The Compassion Capital Fund, a key part of the President's Faith-Based and Community Initiative, was established to provide funds targeted to assist small, grassroots faith-based and community organizations. In FY 2002, ACF awarded nearly \$25 million to 21 intermediary organizations that will help smaller faith-based and grassroots organizations operate and manage their programs more effectively, access funding from varied sources, develop and train staff,

expand the types and reach of social service programs in their communities, and replicate promising programs.

In addition to providing technical assistance, these intermediary groups will issue sub-awards directly to targeted faith- and community-based organizations to expand or replicate promising or best practices. Priority for sub-awards is expected to be given to organizations that focus on homelessness, hunger, at-risk children, transition from welfare to work, and those in need of intensive rehabilitation such as addicts or prisoners. To encourage organizations to work in partnership with the federal government, intermediary organizations were expected to provide at least 50 percent of the amount of federal funds requested (i.e., one-third of the proposed total budget).

Approximately \$2 million was awarded to establish the Compassion Capital Fund National Resource Center. The National Resource Center will work directly with the intermediary organizations to ensure that faith- and community-based organizations receive effective and appropriate technical assistance, and it will develop a comprehensive plan to oversee and coordinate the work of intermediary organizations that receive Federal funding. In addition, the National Resource Center will develop and maintain a clearinghouse and Web site that provide a wide array of information useful to intermediary organizations and faith-based and community organizations, such as "best practices" on meeting the needs of individuals and families, and information on program outcomes and effectiveness. It will also develop manuals on specific topics that will assist intermediary organizations and the faith-based and community organizations they serve.

Approximately \$1.6 million was awarded to support research on the services and best practices of intermediary organizations and the faith-based and community organizations they serve. Approximately \$1 million was awarded to four organizations to support short-term research projects that will contribute to the knowledge base regarding roles and promising approaches by diverse types of faith- and community-based organizations.

As part of the faith- and community-based management improvement initiative, ACF initially proposed tracking the number of applications received in FY 2002, increasing outreach efforts, assessing the quality of applications and providing a technical assistance plan for four discretionary grant programs in four program activity areas: Urban and Rural Community Economic Development, Assets for Independence, Adoption Opportunities and Runaway and Homeless Youth Programs. At that time, because ACF was unable to track increases in applications received from these organizations, ACF proposed creating a baseline indicating the percent of grants approved in FY 2001 for faith- and community-based organizations (FBOs and CBOs) in four selected program areas.

PERFORMANCE MEASURE FOR FY 2001

Developmental Input Indicator	Programs	FY 2001 (baseline)
The percentage of faith- and community-based organizations funded by selected discretionary grant programs.	Urban/Rural Com. Econ. Dev.	100%*
	Assets for Independence	90%**
	Adoption Opportunities	50%***
	Runaway and Homeless Youth Programs	100%****

*Legislation requires that all grantees must be Community Development Corporations (CDCs).

**Eight of the 81 grantees are county or city governments; the remainder are CBOs and FBOs.

***Of the 67 grantees, 33 are faith- and community based, 32 are State, city and county grantees and 2 are university grantees.

****All 634 grantees are faith- and community based.

Since FBOs and CBOs are currently the primary recipients (between 90 percent and 100 percent) of discretionary grant funds in three of the four selected areas, ACF determined this was not a meaningful measure for improving performance. However, a voluntary survey instrument that would be an addendum to the standard grant application forms and would provide additional information about applicant organizations has been developed and is under review at OMB. If approved by OMB and used by ACF, this instrument, the *Survey on Ensuring Equal Opportunity for Applicants*, will allow ACF to obtain substantially more specific information about the types of organizations seeking funding, including whether or not the applicant is a faith-based/religious organization, the size of the organization, whether the organization has received other government funding.

PROGRAM DESCRIPTION AND CONTEXT

ACF has endeavored to embrace the principles of GPRA by reinventing the way it does business through partnership building, strategic planning, measurable outcomes, customer focus, streamlining of operations and devotion to quality. ACF's goal of managing resources to improve performance has brought about changes in its internal management. Efforts in recent years include:

- Promoting fiscal integrity and financial management accountability by establishing strong, collegial, cooperative relationships among program and/or staff managers and employees in ACF, the Program Support Center, the Office of the Assistant Secretary for Budget, Technology, and Finance, Office of the General Counsel, Office of Inspector General, and the audit firm of Clifton Gunderson LLP in order to identify systems or procedural problems and establish and implement corrective actions as quickly as possible;
- Reengineering the grants management business process to improve service to partners and achieve greater efficiency;
- Surveying partners and customers for assessment and guidance on the quality and appropriateness of ACF's services;

- Partnering with other Federal Agencies to support the Government-wide Federal Commons project where potential grantees will be able to apply for grant funds through a single portal on the Internet in the future; and
- Establishing a presence on the World Wide Web;
- Investing in internal systems improvement and technology so that current and potential ACF grantees can apply for grant funds over the Internet through On-line Data Collection;
- Participating in the Department's response to the President's Management Agenda (PMA) to improve the management and performance of government, and establishing an internal reporting mechanism to discuss and share ACF's status on the PMA initiatives;
- Developing an ACF Work force Restructuring Plan based on the goals of the PMA and in support of the Department's management initiatives;
- Establishing performance contracts between the Assistant Secretary and ACF senior staff that include GPRA goals and the Department's response to the PMA, as well as the Assistant Secretary's priorities for the agency;
- Participating in the Work force Planning Project work group (part of a larger HHS effort), which identified cross-cutting work processes with needed core and technical competencies for the next three to five years and provided recommendations for future training and expansion of staff based on a competency assessment of the ACF work force;
- Reinventing the regional office structure to locate resources where partners most need them;
- Developing and implementing diversity and minority initiatives that allow for alignment of the work force with the goals and priorities and help ACF achieve its diversity objectives that reflect all groups including the most under-represented populations;
- Establishing a successful labor-management cooperative agreement with the National Treasury Employees Union (which represents the bargaining unit);
- Investing in technology such as videoconferencing equipment and satellite linkages to bring central office, regional offices and partners closer together and to save on travel costs; and
- Developing an agency strategy to enhance the skills and productivity of the ACF work force through a range of learning options, including on-line e-learning, blended learning (classroom plus e-learning), and other available staff development opportunities.

8. DEVELOP AND RETAIN A HIGHLY SKILLED, STRONGLY MOTIVATED STAFF

Approach for the Strategic Objective: Change the way ACF does business by maintaining or increasing values such as effectiveness, efficiency, and diversity while promoting continuous learning opportunities.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
8.1a.1. Each ACF staff member participates in at least one developmental learning opportunity to enhance his/her skills and productivity.	FY 04: 80% FY 03: 80%	FY 04: FY 03: 7/03 FY 02: 100% Baseline	Px 162 
8.1a.2. Each ACF staff member participates in at least one Distance Learning or other training opportunity directly related to increasing his/her job skills. (Replaced by 8.1a.1)	FY 02: 100% FY 01: 100% FY 00: NA	FY 02: 7/03 FY 01: 96%	
Total Funding (dollars in millions) See detailed Budget Linkage Table in Part I for line items included in funding totals.	FY 04: \$176.3 FY 03: \$173.3 FY 02: \$173.0 FY 01: \$173.2 FY 00: \$147.8 FY 99: \$144.5	Bx: budget just. section Px: page # performance plan	

PROGRAM DESCRIPTION AND CONTEXT

ACF's objective to "develop and retain a highly skilled, strongly motivated staff" has been tracked since FY 2000. For many years, ACF has confronted shrinking staff levels, resources and a loss of knowledge and skills due to attrition and separations. These combined challenges, within an agency with a work force three-quarters of which are eligible to retire by 2006, focused ACF efforts to continue to develop a highly skilled, diversified staff to carry out its mission in the twenty-first century. To address these issues, ACF is building upon a culture of continuous learning and developing an agency training strategy that provides training and developmental learning opportunities to enhance skills and productivity. ACF is addressing the needs of the existing staff and new hires by offering developmental opportunities to support restructuring and redeployment of staff in mission-critical positions, while supporting a diversity and minority initiative to ensure that ACF's work force reflects all groups, including the most under-represented populations. ACF's aim is to build, sustain, and effectively deploy a skilled, knowledgeable, diverse, high-performing, technologically advanced work force to meet the current and emerging needs of the government and the public.

PROGRAM PERFORMANCE ANALYSIS

ACF has been a leader in providing a rich curriculum of on-line learning to all staff, including over 1300 vendor-provided courses, as well as ACF-developed on-line courses such as security awareness training provided to all staff and on-site contractors in FY 2001-2002. In FY 2002, ACF began a much more focused blended learning approach to enhance the skills and productivity of all ACF staff and on-site contractors by integrating on-line learning with classroom training for a new e-mail system and personal productivity tools.

E-learning is just one component, albeit a very important tool, of a blended learning approach. ACF is now moving its focus from emphasizing the e-learning tool to assuring that the learning strategies are appropriate to the individual learner, and to ensuring that individual and organizational learning are in alignment with the agency's business goals. By linking business needs to performance strategies, enhancing individual and organizational productivity, and developing a culture for organizational learning and continuous learning, ACF will leverage limited resources to enhance job competencies. What ACF has learned over the last two years is that it is not primarily about e-learning: it's about improving people performance, which leads directly to better business results. The success of ACF's strategic goal "to develop and retain a highly skilled, strongly motivated staff" rests on enhancing the skills of every ACF staff member through all avenues available from traditional to leading edge—whether that means creating a learning organization, effecting organizational change, developing the work force, or helping to build the HHS corporate university.

Examples of strategies that have proven most successful in developing and retaining a highly skilled, strongly motivated staff include:

- Implementing the *Balanced Scorecard* to expand its performance measurement system to include *customer service* feedback and *employee satisfaction*, as well as its program measurement system focused on results; and
- Initiating in FY 2001 on-line Distance Learning through FasTrac (a learning consortium at the National Security Agency) to strengthen and significantly expand learning opportunities that address the professional development needs of ACF staff in a changing workplace.
- Providing access to all ACF Federal employees to more than 1300 technical and non-technical training courses and to a rich variety of in-house skills-enhancement and other staff development and learning opportunities. All employees were provided training in the agency-wide migration to the new e-mail system--Microsoft Outlook 2000 and intensive computer security awareness training during FY 2002.

In addition, in response to concerns following the September 11 tragedy and subsequent anthrax scares, ACF arranged for an Army Colonel on the Secretary's Bio-Terrorism Task Force to speak to interested employees about the government's strategy regarding anthrax prevention. ACF also established a new in-house Security Officer position to address employee and facility security issues.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Develop and retain a highly skilled, strongly motivated staff

8.1a. FY 2003: *Each ACF staff member participates in at least one developmental learning opportunity to enhance his/her skills and productivity.*

FY 2004: *Each ACF staff member participates in at least one developmental learning opportunity to enhance skills and productivity.*

Data Source: ACF Administrative Records

ACF staff will be encouraged to avail themselves of at least one training opportunity although it will not be required. Because it is voluntary, ACF projects an 80 percent target for this activity.

9. STREAMLINE ACF ORGANIZATIONAL LAYERS

Approach for the Strategic Objective: Implement restructuring plan to reduce bureaucratic levels, maintaining or increasing values such as effectiveness, efficiency and diversity while reducing the number of managers to assure that ACF is more responsive to its customers and citizens.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
9.1a. Decrease ACF's manager-to-staff ratio (replaces former FY 00 measure 9.1a)	FY 04: TBD FY 03: TBD	FY 04: FY 03: FY 02: (baseline)	Px 163 

PROGRAM DESCRIPTION AND CONTEXT

While ACF has undertaken several methods to ensure steady progress toward this goal, including reorganizations, elimination of duplicative units, consolidations, employee reassignments and creative use of technology, progress towards this goal has been limited. Main factors include personnel attrition, a limited administrative budget and limitations on outside hiring. As part of its succession planning activities, ACF intends to use the Presidential Management Intern and HHS Career Intern programs, as well as other targeted recruitment, to hire new government workers to fill mission-critical positions. This strategy should assist ACF in meeting its goal of decreasing the manager-to-staff ratio, thereby reducing the number of managers and the time

required for decision-making. FY 2002 will provide a baseline for this FY 2003 performance measure and realistic targets will be based on the Work force Restructuring Plan.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

9.1a. FY 2003: *Decrease ACF's manager to staff ratio.*

FY 2004: *Decrease ACF's manager to staff ratio.*

Data Source: ACF Personnel Records

10. IMPROVE AUTOMATED DATA AND MANAGEMENT SYSTEMS

Approach for the Strategic Objective: Continue to invest in systems improvement and technology to allow greater access for ACF staff to move forward in a working environment which increasingly requires that all employees have access to and use of the Internet as an integral part of day-to-day agency operations. With continued investments in upgrading hardware and software, ACF will assure that staff have access to information and technology and run the applications that are critical to performing their jobs in an Internet-oriented age.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
10.1a.1 Implement a funds planning capability to manage and track all grant funds and planning mechanization. (New)	FY 04: Complete Phases 1, 2 and 3	FY 04:	Px 165 
10.1a.2 Operate and maintain the On-line Data Collection system (OLDC), which will capture and validate grant information submitted by grantees using the Web.	FY 03: OLDC	FY 03:	Px 165 
10.1a.3 Develop and implement OLDC, to capture and validate grant information submitted by grantees using the Web.	FY 02: OLDC FY 01: GATES II	FY 02: Alpha version completed. Beta version to be tested and implemented in March 2003. FY 01: Completed	

PROGRAM DESCRIPTION AND CONTEXT

Historically, ACF processed grants using more than 30 separate computer programs (application systems). In 1993, ACF initiated a re-engineering of its business processes, challenging the purpose, principles and assumptions of ACF's grant processes and abandoning the outdated grant-making and management procedures and separate rules for various categories of grants. In July 1994, the ACF Grants Re-engineering Team published its report. The report recommended an organizational restructuring of the way ACF does business, establishing a quality assurance framework and supporting re-engineered grants administration activities with a major redesign of the automated information systems.

A systems re-engineering team began developing an integrated system, the Grants Administration, Tracking and Evaluation System (GATES), designed to support decision-making and accountability in a decentralized environment. This project targeted the replacement of more than 30 incompatible, outmoded legacy systems operating on a variety of platforms supporting grants administration. This re-engineered GATES, a comprehensive system for electronic processing, benefited grantees by providing more timely and efficient grants processing, more accurate data, less down time and quicker start-up.

PROGRAM PERFORMANCE ANALYSIS

In FY 1996 and FY 1997, ACF completed developing and implementing GATES system functions supporting application, evaluation, award and funds control activities for Discretionary Grants made to non-profit and Native American organizations. In FY 1998, 22 legacy systems were replaced. The FY 1999 target was to replace 15 additional legacy systems. The deployment of the Entitlements portion of GATES in June 1999 completed the replacement of the additional 15 systems. Now 100 percent of the active ACF grants are being processed electronically in GATES. Replacement of these legacy systems with GATES also corrected the Year 2000 programming flaw embedded in them. All Y2K system replacements were completed by December 31, 1998.

ACF completed the full functionality planned for GATES. The Audit resolution tracking process (measure 10.1c) was implemented in GATES and the old system shut down in August of 2000. ACF adopted the Crystal Report Writing software that allows the user community to retrieve information in GATES efficiently and quickly. Both standard and ad hoc reporting retrieval is possible. Crystal Report writer licenses have been distributed and training conducted throughout the ACF grant and program offices. Additionally, OIS has set up a Crystal Report support system to assist users with the development and usage of the standards and ad hoc GATES reports. This was implemented in June 2000. Enhancements for tying in to the Bureau of Census' Federal Clearinghouse, as well as debt collection capabilities, were scheduled in the 2001 module.

GATES schedules were developed jointly with each Program Office and Region affected through Joint Application Development (JAD) meetings with crosscutting representation in small face-to-face meetings and telephone conferences. The formula/block award modules were implemented on schedule. This completes the legacy conversion/replacement efforts. Now, all grants are awarded through GATES. ACF is developing a funds planning component in GATES

to enable management to effectively plan, monitor and manage grant expenditures. ACF anticipates that the Phase 1 component will be operational by the end of FY 2003.

ACF is implementing the next generation of electronic grant-making using an "On-line Data Collection (OLDC) Initiative" to enable grantees and potential grantees to submit the required information over the Internet. Plans have been presented to the Information Technology Review Board (ITRB) consistent with the new Government Paperwork Elimination Act.

Synchronization of the databases between OLDC and GATES is proving to be difficult and is requiring extensive testing efforts. Additionally, the GATES software had to be upgraded to be W2K compliant.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

PROGRAM GOAL: Benefit grantees by improving automated data and management systems.

- 10.1a2** **FY 2003:** *Complete and maintain OLDC, which will capture and validate grant information submitted by grantees using the Web.*
- 10.1a1** **FY 2004:** *Implement a funds planning capability to manage and track all grant funds and planning mechanization. (new)*

Data Source: ACF Administrative records

11. ENSURE FINANCIAL MANAGEMENT ACCOUNTABILITY

Approach for the Strategic Objective: Improve financial and budgetary functions by adopting a more results-oriented, businesslike approach to management and oversight of its fiscal resources.

Summary Table

Performance Measures	Targets	Actual Performance	Reference (page # in printed document)
11.1a. Obtain a clean audit opinion for ACF.	FY 04: Clean opinion FY 03: Clean opinion FY 02: Clean opinion	FY 04: FY 03: FY 02: 6/03 FY 01: Clean Opinion FY 00: Clean opinion FY 99: Clean opinion	Px 166 

PROGRAM DESCRIPTION AND CONTEXT

ACF first submitted its annual audited financial statements in FY 1996 as a result of the Department's strategy for implementing requirements under the Chief Financial Officers' Act of 1990, as amended by the Government Management Reform Act (GMRA) of 1994. Under the HHS plan, ACF was designated as an individual reporting component requiring an annual financial statements audit of its activities. ACF and other OPDIV annual audited financial statements are "rolled up" and the HHS audited financial statements package is presented in the annual Accountability Report consolidating several financial management reports with selective performance measurement information.

PROGRAM PERFORMANCE ANALYSIS

ACF works closely with the Program Support Center (PSC), the accounting firm that develops the ACF financial statements, the Assistant Secretary for Budget, Technology and Finance (ASBTF), Office of Inspector General, Office of General Counsel, and the private audit firm of Clifton Gunderson, LLP, to complete the annual financial statements audit. The President's Management Agenda states that by the FY 2002 audit cycle all 24 cabinet level departments will pass their audits. ACF received a "clean" or unqualified opinion from the auditors for FY 1999-2001 and continues to work aggressively to maintain this accomplishment. In FY 2001, ACF achieved the clean opinion without any material weaknesses. ACF, the Department, and ACF's auditors are dedicated to improving the accounting systems and services that support the development of ACF's audited financial statements. This collaboration is essential for ACF to meet the compressed deadlines for the FY 2002 and future audit cycles. ACF will continue to work closely with its partners to correct remaining problems identified by the auditors.

Performance Plan

Performance Measures for FY 2004 and Final Measures for FY 2003

11.1a. FY 2003: *Obtain a clean audit opinion for ACF.*

FY 2004: *Obtain a clean audit opinion for ACF.*

Data Source: Clifton Gunderson, LLP, Independent Auditor's Report

APPENDICES

A.1 LINKAGE TO HHS AND OPDIV STRATEGIC PLANS

HHS STRATEGIC GOALS*	CORRESPONDING ACF STRATEGIC GOALS, OBJECTIVES AND STRATEGIES
GOAL 1: REDUCE THE MAJOR THREATS TO THE HEALTH AND WELL-BEING OF ALL AMERICANS <i>1.2 Reduce the incidence of sexually transmitted diseases and unintended pregnancies</i> <i>1.6 Reduce the incidence and consequences of injuries and violence</i>	GOAL 2: IMPROVE HEALTHY DEVELOPMENT, SAFETY AND WELL-BEING OF CHILDREN AND YOUTH <i>6. Increase safety, permanency, and well-being of children and youth</i> <i>6.5a Enhance child well-being by promoting healthy marriages and family formation and reducing out-of-wedlock pregnancies</i> GOAL 3: INCREASE THE HEALTH AND PROSPERITY OF COMMUNITIES AND TRIBES <i>7.2 Support programs to provide immediate shelter and related assistance for victims of family violence and their dependents</i>
GOAL 3: INCREASE THE PERCENTAGE OF THE NATION'S CHILDREN AND ADULTS WHO HAVE ACCESS TO HEALTH CARE SERVICES AND EXPAND CONSUMER CHOICES <i>3.2 Strengthen and expand the health care safety net</i> <i>3.4 Eliminate racial and ethnic health disparities</i> <i>3.5 Expand access to health care services for targeted populations with special health care needs</i> <i>3.6 Increase access to health services for American Indians and Alaska Natives</i>	GOAL 2: IMPROVE HEALTHY DEVELOPMENT, SAFETY AND WELL-BEING OF CHILDREN AND YOUTH <i>5. Promote early childhood development</i> <i>5.2 Children demonstrate improved physical health</i> <i>6. Increase safety, permanency, and well-being of children and youth</i> <i>6.3 Increase the number of health care providers trained to meet the health needs of people with developmental disabilities</i>
GOAL 5: IMPROVE THE QUALITY OF HEALTH CARE SERVICES <i>5.2 Increase the appropriate use of effective health care services by medical providers</i>	GOAL 2: IMPROVE HEALTHY DEVELOPMENT, SAFETY AND WELL-BEING OF CHILDREN AND YOUTH <i>5. Promote early childhood development</i> <i>6. Increase safety, permanency, and well-being of children and youth</i> <i>6.3 Increase the number of health care providers trained to meet the health needs of people with developmental disabilities</i>

HHS STRATEGIC GOALS*	CORRESPONDING ACF STRATEGIC GOALS, OBJECTIVES AND STRATEGIES
GOAL 6: IMPROVE THE ECONOMIC AND SOCIAL WELL-BEING OF INDIVIDUALS, FAMILIES, AND COMMUNITIES, ESPECIALLY THOSE IN NEED <i>6.1 Increase the proportion of low-income families and persons receiving welfare who improve their economic status</i>	GOAL 1: INCREASE ECONOMIC INDEPENDENCE AND PRODUCTIVITY FOR FAMILIES <i>1. Increase employment</i> <i>2. Increase independent living</i> <i>3. Increase parental responsibility</i> <i>4. Increase affordable child care</i> <i>6. Increase safety, permanency, and well-being of children and youth</i>
<i>6.3 Increase independence and quality of life of persons with disabilities, including those with long-term care needs</i>	GOAL 1: INCREASE ECONOMIC INDEPENDENCE AND PRODUCTIVITY FOR FAMILIES <i>1. Increase independent living</i> GOAL 2: IMPROVE HEALTHY DEVELOPMENT, SAFETY AND WELL-BEING OF CHILDREN AND YOUTH <i>6.3 Increase the number of health care providers trained to meet the health needs of people with developmental disabilities</i>
<i>6.4 Improve the economic and social development of distressed communities</i>	GOAL 3: INCREASE THE HEALTH AND PROSPERITY OF COMMUNITIES AND TRIBES <i>7. Build healthy, safe and supportive communities and Tribes</i>
<i>6.5 Expand community- and faith-based partnerships</i>	<i>The number of unduplicated faith- and community-based organizations that receive technical assistance to increase the capacity to provide needed social services**</i>
GOAL 7: IMPROVE THE STABILITY AND HEALTHY DEVELOPMENT OF OUR NATION'S CHILDREN AND YOUTH <i>7.1 Promote family formation and healthy marriages</i>	GOAL 2: IMPROVE HEALTHY DEVELOPMENT, SAFETY AND WELL-BEING OF CHILDREN AND YOUTH <i>6. Increase safety, permanency, and well-being of children and youth</i> <i>6.5a Enhance child well-being by promoting healthy marriages and family formation and reducing out-of-wedlock pregnancies</i>
<i>7.2 Improve the development and learning readiness, as appropriate, of infants, toddlers, and preschool children</i>	<i>4. Increase affordable child care</i> <i>5. Promote early childhood development</i>
<i>7.3 Increase the involvement and financial support of non-custodial parents in the lives of their children</i>	<i>3. Increase parental responsibility</i>
<i>7.4 Increase the percentage of children and youth living in a permanent, safe environment</i>	<i>6. Increase safety, permanency, and well-being of children and youth</i>

HHS STRATEGIC GOALS*	CORRESPONDING ACF STRATEGIC GOALS, OBJECTIVES AND STRATEGIES
GOAL 8: ACHIEVE EXCELLENCE IN MANAGEMENT PRACTICES	GOAL 4: MANAGE RESOURCES TO IMPROVE PERFORMANCE
<i>8.1 Improve the strategic management of human capital.</i>	<i>8. Develop and retain a highly skilled, strongly motivated staff</i>
<i>8.3 Improve financial management</i>	<i>9. Streamline ACF organizational layers</i>
<i>8.4 Enhance the use of electronic commerce in service delivery and record keeping</i>	<i>11.Ensure financial management accountability</i>
<i>8.5 Achieve integration of budget and performance information</i>	<i>10. Improve automated data and management systems</i>
	<i>Budget crosswalk and budget linkage tables</i>

*The HHS strategic goals reflect those in the draft HHS Strategic Plan dated November 2002.

**This measure is still under development and has not been assigned a strategic objective number.

A.2 CHANGES AND IMPROVEMENTS OVER PREVIOUS YEAR

ACF has made a number of improvements in this FY 2004 Annual Performance Plan. The FY 2004 plan includes additional information on detailed changes between the Final FY 2003 Plan and the Revised Final FY 2003 Plan, including which targets have been revised, which have been discontinued and which are still developmental. Each of the ACF programs was asked to re-examine its measures and targets to align them with Administration priorities. As a result, many programs created a more focused set of measures, e.g., dropping some measures, providing improved measures and targets based on the most recent available data and narrowing or refining existing measures.

Part I provides additional information that includes a roadmap explaining how the plan is organized and a description of ACF's key priorities and performance budget linkages.

In Part II, under each of the strategic goals and objectives, performance goals and measures are discussed in greater detail with a fuller discussion of program activities and strategic approaches directed at improving performance. Program performance analysis and resource and data issues are summarized and a budget table linking investments to activities, outputs and outcomes is included.

ACF has endeavored to project targets based on trend data wherever possible. There are a few measures that still lack baselines because programs are implementing new initiatives and data collection activities. Baselines for those measures will be established upon completion of start-up and developmental activities. In a few cases, the targets or measures are stated in ways that cause baselines to change annually (e.g., continuous improvement targets or legislatively defined targets). For those, a context has been provided in the narrative.

More descriptive information has been provided in a number of areas: (1) addition and/or deletion of measures to reflect new program priorities; (2) revision of targets to reflect program experience retaining the same baseline data wherever possible; (3) explanation for targets not achieved and steps that will be initiated to correct shortfalls; (4) additional narrative explaining the FY 2003 and 2004 measures; and (5) a status update on FY 2002 data and detailed changes between the FY 2003 Plan and the Revised Final FY 2003 Plan.

Both the FY 2003 and FY 2004 targets are repeated in the narrative section. Because the measures in the summary tables tend to be generic and programs are still refining the wording of many of the measures, it is critical that the specific wording be included in the narrative section for future tracking purposes.

STATUS OF FY 2002 DATA AND DETAILED CHANGES BETWEEN THE FINAL FY 2003 PLAN AND THE REVISED FINAL FY 2003 PLAN

Includes changes, status of developmental measures and availability of data for FY 2002 Performance Report. Measures are not listed if they remain as they were presented in the Final FY 2003 Annual Performance Plans (APP).

1. Increase employment.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (EMPLOYMENT)

Status of measures: FY 2002 results will be available September 2003. States are given up to 3 months to provide data for each quarter. Time is needed to validate and verify the data. A developmental measure, 1.1f, has been added to assess the rate of case closure due to employment.

DEVELOPMENTAL DISABILITIES (EMPLOYMENT)

Status of measures: FY 2002 results will be available for measures 1.3a-b March 2003. Measure 1.3b has been dropped for FY 2003.

REFUGEE RESETTLEMENT

Status of measures: Annual, unduplicated FY 2002 data are due 45 days after end of year, circa November 15. Because individual State reports may be missing and time is needed to validate and verify the data, final State data will be available April 2003; final MG data July 2003. For measures 1.4a, b and d, the percentages have been revised downward based on caseload fluctuations. Measure 1.4c has been dropped.

SOCIAL SERVICES BLOCK GRANT

Status of Measures: FY 2002 results will be available June 2003. Measure 1.5d has been re-phrased to be more reflective of program dynamics and funding levels. The remaining four measures (1.5a-c and 1.5e) have been dropped.

2. Increase independent living.

DEVELOPMENTAL DISABILITIES (HOUSING)

Status of measures: FY 2002 data will be available March 2003.

INDIVIDUAL DEVELOPMENT ACCOUNTS

Status of Measures: FY 2002 results will be available June 2003. Measure 2.2a has been replaced by a developmental measure, 2.2c, with baseline being developed in FY 2003. Measure 2.2b has been dropped.

3. Increase parental responsibility.

CHILD SUPPORT ENFORCEMENT

Status of measures: FY 2002 results will be available September 2003.

4. Increase affordable child care.

CHILD CARE: AFFORDABILITY

Status of measures: FY 2002 results will be available December 2003. Most of the data for these measures are from State reports, due the end of CY 2002. Five measures, 4.1a-c, 4.1e and 4.1g, have been replaced by three developmental measures, 4.1d, 4.1f, and 4.1h with baselines being developed in FY 2003.

5. Increase quality of child care to promote childhood development.

CHILD CARE: QUALITY

Status of measures: See CHILD CARE: AFFORDABILITY above. FY 2002 results will be available for measure 5.1b in February 2003 and measures 5.1a and 5.1d in December 2003. Measures 5.1b and 5.1d have been dropped in FY 2003 and a baseline for one developmental measure (5.1c) has been added in FY 2003 to be more reflective of new program priorities.

HEAD START

Head Start has set more aggressive targets for measures 5.2a, 5.2b and 5.2e. Measures 6.1a-c have been moved under strategic objective 5 (now 5.2l-n) to reflect the integrated nature of the program's child development strategies.

6. Increase safety, permanency, well-being of children and youth.

CHILD WELFARE

Status of measures: FY 2002 final results for most measures will be available in June 2003. Measure 6.1g was dropped in FY 2003. Measure 6.1b and 6.1f will be available September 2003.

DEVELOPMENTAL DISABILITIES (EDUCATION)

Status of measures: FY 2002 data will be available March 2003. Measure 6.2a has been dropped for FY 2003.

DEVELOPMENTAL DISABILITIES (HEALTH)

Status of measures: FY 2002 data will be available January 2003.

YOUTH PROGRAMS

Status of measures: Measures 6.4b and 6.4g have been dropped, baseline for one developmental measure, 6.4h, has been added in FY 2003 to reflect program priorities and targets for FY 2002 and 2003 have been added for 6.4c.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (CHILD WELL-BEING)
Status of measures: FY 2003 baseline for a new developmental measure, 6.5a, has been added to reflect program priorities.
<i>7. Build healthy, safe & supportive communities and Tribes.</i>
COMMUNITY SERVICES
Status of measures: FY 2002 final results will be available July 2004. The target for measure 8.1b has been increased from one percent to two percent.
FAMILY VIOLENCE PREVENTION
Status of Measures: No change in status.
LOW INCOME HOME ENERGY ASSISTANCE (LIHEAP)
Status of measures: Measure 7.3c, a developmental measure, has been dropped due to data issues. FY 2003 targets were developed for measures 7.3a-b.
NATIVE AMERICANS PROGRAMS
Status of measures: 7.4b has been dropped and a baseline will be developed in FY 2003 for a developmental measure (7.4c) to reflect the program's emphasis on economic development.
A RESULTS-ORIENTED ORGANIZATION
<i>8. Develop and retain a highly skilled, strongly motivated staff</i>
Status of measures: FY 2002 final results will be available July 2003.
<i>9. Streamline ACF organizational layers</i>
Status of measures: No change in status.
<i>10. Improve automated data and management systems</i>
Status of measures: FY 2002 final results will be available June 2003.
<i>11. Ensure financial management accountability</i>
Status of measures: FY 2002 final results will be available June 2003.

A.3 PARTNERSHIPS AND COORDINATION

ACF and its partners began "focusing on results" before GPRA was in effect. Efforts to reach consensus on outcomes prompted extensive discussion of strategic objectives, legislative requirements, data sources and availability; led to a fuller understanding of outcomes and the relationships to process and output measures; and fostered closer partnership collaborations. Continuous program improvement has required ongoing consultation, technical assistance, and coordination across partnerships resulting in some performance measures being modified, dropped or replaced.

Partnerships with States: Results-oriented partnership agreements and targets have been negotiated with individual States. Each program has developed an individualized process for engaging partners in goal setting and definition of measures and targets that are meaningful and useful at the State and local community level. For example, ACF undertook a legislatively-mandated, partner-oriented process to develop the measures and funding formulas used to award TANF high performance bonuses to States. Also, the child support program developed with States a national strategic plan with indicators and targets. The refugee program involved both State refugee programs and community-based service organizations in the development of measures and targets. In some programs, such as child care, which were new but had no mandated requirement for consultation like TANF, a preliminary set of proxy measures was developed for the first GPRA planning years, while the program undertook a consensus-building process with the partnership constituencies.

Partnerships within ACF: ACF has created an array of initiatives that cut across program boundaries and service areas. For example, ACF is integrating its performance systems relating to child care to include resources from the Child Care Bureau, TANF and SSBG, as well as activities under Head Start. ACF's Administration on Developmental Disabilities has developed results-based management systems relating to housing, health services, employment and education. And, the Assets for Independence program, which manages the Individual Development Accounts, collaborates with LIHEAP to ensure energy efficiency and a sound return on investment for low-income homeowners.

Partnerships within HHS: Across HHS, a large number of programs share related objectives. Interagency consultation has taken place across programs within ACF, (e.g., child care and Head Start, child support and TANF) and within HHS (e.g., between TANF and Medicaid) through seminars and forums convened by the Office of the Assistant Secretary for Budget, Technology and Finance (ASBTF) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Special efforts have been directed to assure that children have access to health and child development services. Head Start and the Child Care Bureau work with HHS health agencies e.g. the Maternal and Child Health Bureau, Community Health Centers, the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Centers for Medicare and Medicaid Services (CMS) to achieve health targets. For example, Child Care and Head Start coordinate with the Health Resources and Services Administration's (HRSA) Maternal and Child Health

program to improve health and safety in child care by creating strong links with health communities. Increasing the number of women who receive early and comprehensive prenatal care is among the salient goals of the Early Head Start program, which serves low-income families with infants and toddlers. ACF programs provide outreach for the State Child Health Insurance Program (SCHIP), which is administered by the Centers for Medicare and Medicaid Services. Head Start and Child Care jointly sponsor the QUILT (Quality in Linking Together) project that helps Head Start and child care grantees form program partnerships to provide high quality full-day, full-year early childhood services. Such coordination at the implementation and delivery level is producing significant results.

Partnerships with other Federal Agencies: Given that ACF measures have been developed in collaboration with partners, the consultation process outside of ACF has been extensive, though more so with ACF's program partners, such as States and grantees, than with other Federal agencies. ACF works closely with Federal Departments such as Labor, Treasury, Housing and Urban Development, Education and Transportation in implementing, operating and improving welfare reform, early child development, child care, child support, and other programs. Consultation with Federal agencies outside of HHS on specific GPRA performance plan issues has not been a formal process. Program-specific data and measurement issues, as well as differing statutes and populations served, make the development of common measures more challenging. However, ACF has found that intensive consultation and coordination on program design and objectives provide a climate for close alignment among programs with similar goals. Performance measurement issues are central to cross-agency discussions, e.g., identifying State unemployment records as a data source for TANF performance measures. There has been extensive programmatic collaboration, including TANF and welfare-to-work grants with the Department of Labor; child care and Head Start with the Department of Education; and child support enforcement with the Departments of Justice, Treasury and Defense. These collaborations have helped develop results-oriented strategies that contribute to the success of performance goals.

ACF has been an active participant in cross-program efforts to develop broader indicators of child well-being, e.g., *Trends in the Well-being of America's Children and Youth; America's Children: Key National Indicators of Well-being; Healthy People 2010* and the Children's Indicators Consortium study. ACF is committed to working collaboratively with its partners in the refinement of these broader performance measures and the identification of annual performance targets.

A.4 DATA VERIFICATION AND VALIDATION

Grantees and partners, such as States, collect most data for ACF programs with collection schedules written into statutes and regulations. ACF uses considerable resources to verify and validate program data through automatic edit checks, manual reviews or audits, and other forms of quality control and assurance.

Specific data issues are discussed in the individual performance goal sections. ACF has developed a number of different strategies to deal with these issues. There are a number of broad data-related challenges affecting ACF's performance plan. Resolving these challenges (listed below) and other data issues is necessary, time-consuming, difficult, and costly.

- Quantitative and qualitative measurement of outcomes in social programs are experimental and still being validated;
- States, Tribes and non-profit grantees vary in their ability to collect, produce and report reliable data;
- Data validation and verification are highly complex and costly;
- Particularly for our numerous new or changed programs, baseline data are frequently unavailable and must be developed before progress can be measured;
- Data collection systems fully geared to State flexibility are still being implemented; and
- Investments in the design, development and implementation of data collection systems are costly and must be balanced against other priorities at all levels – Federal, State and local.

Many ACF grantees receive programmatic funds that the legislation either designates or permits to be used for data collection. Discretionary, formula, and entitlement grant awards generally carry reporting requirements directed at facilitating oversight and measuring performance. However, block grants and devolution of program authority to States have resulted in limitations on ACF's collection of data. ACF has worked with its partners to collect a reasonable amount of data from which to determine performance and assure program integrity.

For a number of major programs, ACF is largely dependent upon State administrative systems for collecting performance data, e.g., Temporary Assistance to Needy Families, Developmental Disabilities, Refugee Resettlement, Child Welfare, Child Support Enforcement, Child Care, and Low Income Home Energy Assistance Program. For these programs, performance results can be measured and validated through the administrative data.

Currently, ACF has the following major data system infrastructures in place: the National Directory of New Hires (Child Support and TANF), the Unemployment Insurance Wage data (UI), the TANF Data Reporting System, the TANF SSP-MOE Data Reporting System; and the Tribal TANF Data Reporting System; the Child Support Survey; the Residential Energy Consumption Survey; March Current Population Survey (CPS) Supplement (Census Bureau); the Refugee Resettlement Survey; Head Start Family and Child Experiences (FACES) Survey; and the National Child Welfare Longitudinal Study.

Other ACF programs, e.g., Head Start, Youth programs, CSBG, and Family Violence, rely on local community data systems. Native Americans programs use two internal data tracking systems (Project Information and Evaluation System and the Grant Award Tracking and Evaluation System). The Head Start information is collected at local grantee sites through Program Information Reports and the Family and Child Experiences Survey (FACES) which has rigorously defined collection procedures. Several programs use survey information to supplement the data.

As a result of many of the challenges listed above, there is some delay in the availability of administrative data. These delays limit knowledge of current program activity and hinder policy-making and program planning. Some delays are inherent in the goals and measures of the program, e.g., job retention and earnings gain in TANF. ACF reviewed the data reporting time frames for the performance measures in this plan. A chart summarizing the timetables for ACF programs using State and grantee administrative data is included in Appendix A-8.

A.5 PERFORMANCE MEASUREMENT LINKAGES

Information Technology Planning

During the past fiscal year, ACF actively utilized the ACF Information Technology Review Board (ITRB) in accordance with the intent of the Clinger-Cohen Act (also known as the Information Technology Management Reform Act [ITMRA]). The overall purpose of the ACF ITRB is to monitor (1) the performance of selected ongoing major ACF information technology investments or to consider proposed new major investments and (2) matters that concern ACF IT policies and issues. The ACF ITRB completed, or is implementing, 10 priority Investment Technology policies:

- IT procurements: ACF will implement annual, centralized replacement planning and purchasing for PC's and related equipment. Replacement budget plans will be presented annually to the ACF ITRB for approval.
- Standard desktop PC hardware: ACF implements a standard desktop PC hardware configuration.
- Standard PC software: ACF implements and maintains a standard desktop PC software configuration.
- IT training: ACF has centralized its plans and budgets for all technical training. Training for all ACF standard PC software is available in a classroom setting and through our Distance Learning initiative. Training in each software is provided through centralized budgets.
- Internet/Intranet technologies: ACF will provide enhanced support for Internet and Intranet publishing by operating state-of-the-art web servers and related technologies. Central Office/Regional Office Internet web page content is subject to Office of Public Affairs review to ensure compliance with applicable policies and procedures.
- ACF network remote access: ACF will expand and enhance its remote access services agency-wide to meet the 21st Century work environment. The results of feasibility studies and analyses of alternatives will be presented for review by the ITRB, when available.
- Desktop video conferencing: ACF will continue to improve capabilities for point-to-point video conferencing within ACF, and/or Internet-based video conferencing within ACF and/or with outside parties (within available budgets including, possibly, program funds). Future recommendations will be presented to the ITRB under the leadership of the videoconferencing team and Region VI.
- HHS-wide administrative systems: ACF working with the Department to create uniform administrative systems, which will begin with a new Web-based HR/Payroll system that will provide the Department with higher quality HR service and integrated functionality.
- On-line Data Collection (OLDC): ACF will implement a next generation of electronic grant-making through the OLDC capability to enable grantees and potential grantees to enter all grants information on-line over the Internet. Plans and designs presented to the ITRB are consistent with the new Government Paperwork Elimination Act.
- Electronic file storage: ACF is planning for efficient archiving of documents from paper and/or electronic originals through electronic document management technology. ACF will collaborate with the Department to accomplish this initiative.

In addition, ACF continues to monitor the following IT investments:

- IT support activities associated with the Expanded Federal Parent Locator Service mandated by Welfare Reform Legislation: the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA);
- Completion of Business Process Reengineering of the Grants Administration Process through the use of the Grants Administration Tracking and Evaluation Systems (GATES);
- Continued implementation of IT support activities associated with Temporary Assistance for Needy Families (TANF);
- ACF is working with the Department on several major IT initiatives to implement the Secretary's Five Year Strategic Plan for IT Consolidation and "One Department". ACF is leading the departmental initiative to consolidate the infrastructure of the small OPDIVs creating a uniform standardized configuration. Completion is planned for October 2003; and.
- In support of the "One Department" initiative, ACF is consolidating all IT activities and developing an Enterprise Architecture to guide and improve Capital Planning and Investment Control of IT and business processes across the OPDIV.

Cost Accounting

Beginning in FY 1998, all government reporting entities were required to implement, and be audited on, full cost accounting (also known as managerial cost accounting) as part of the annual financial statements audit process. Beginning with the FY 1998 audit process, ACF was required to present all costs directly associated with a program, as well as all costs indirectly supporting that program. Based on Federal law and OMB guidance, the programs against which these costs had to be reported were ACF's major program areas identified in the GPRA Annual Performance Plan.

To implement a credible and auditable method to fulfill the full cost accounting requirements for the FY 2001 audit, ACF allocated its Federal Administration budget indirect costs proportionately among the major program areas on the basis of direct FTE. (Indirect costs include salaries and benefits for staff not working *directly* on one of the 14 program activities; costs of training, personnel, budget, travel, systems, facilities, supplies, and rent.)

To accomplish this, ACF senior staff in headquarters and the regions completed a Staff Resource Survey providing the total number of staff working directly on program activities in one or more of the major program areas; and the total number of staff not working directly on program activities. Staff in this category included planning, administrative, and front office staff. Fractions of staff were indicated for those working in more than one major program area. Contractors and detailees *out* of an organization were excluded from a manager's count while detailees *into* an organization from another office were included.

Where an organization encompassed one entire major program area, e.g., Developmental Disabilities, Child Support and Native Americans Program, only the total number of on-board staff for that organization were indicated. Staff offices that provided cross-cutting activities

reported on-board staff as "other staff not working directly on program activities." Offices where program distinctions could be made (e.g., ACYF, OCS) reported on both items.

Completed survey data were collated and analyzed in an automated spreadsheet and provided to the HHS Program Service Center (PSC) to allocate the indirect costs in proportion to the resulting direct staff ratio. These data support PSC's development of ACF's Statement of Net Cost. ACF managers were advised to retain documentation that explains how they arrived at their numbers in the event that auditors requested to review this process. ACF's cost accounting strategy was accepted by the auditing firm (Clifton Gunderson), PSC, ASBTF and the OIG. Other OPDIVs also requested copies of our methodology and survey instrument. ACF continues to use the same strategy for each audit cycle, adding new program areas as appropriate.

Work Force Analysis Plan

ACF is committed to being a customer-focused, citizen-centered organization. It is an organization that focuses on results, provides high quality, cost-effective and efficient services, meets customers' needs and expectations, and uses state-of-the-art information technology to improve management and data systems. ACF will continue to rely on its work force analysis plan to support the ACF work force restructuring plan. The ACF work force analysis provides a demographic summary of ACF's permanent work force, an evaluation of the skills of the work force, and an assessment of the organization's structure. In addition, ACF plans to engage in a progressive succession planning effort to address mission-critical activities and gaps in the ACF work force.

ACF analyzed information gathered for work force planning purposes in order to accurately gauge and project current agency workload, current employees' competencies, estimated future workloads and future competency needs for the next three to five years. ACF continues to make progress in implementing administrative consolidations and organizational realignments of some ACF offices.

Program Evaluation

While States have been given increasing latitude in administering programs, they depend on national leadership and partnership in developing reliable information, technical assistance, and the development and dissemination of proven or promising methods for achieving and measuring success. Extant research and early results of major studies under way have helped shape significant changes in Federal and State policy and legislation affecting low-income families and children.

Effective State decision-making requires timely and reliable information on the consequences of alternative policy and program choices and the experiences of other States. As policy and program design has devolved to States and localities, it is vital that these levels of government have reliable information for decision-making and that the effects of different policy and program choices on quality and accessibility are understood. Documenting, understanding, interpreting and facilitating the exchange of information and experiences among States is essential to providing high quality services to promote the well-being of families and children.

As ACF continues to focus on results-oriented management, evaluations play an increasingly important role in program improvement. Program evaluations are directed at evaluating effectiveness, assessing the achievement of performance results, assessing the impacts of human services, and improving program management. Program evaluations are largely directed at assessing the effectiveness of individual projects within a program. The ACF performance measurement system is the primary mechanism used to monitor annual progress in achieving ACF's strategic and performance goals.

Specific Examples of Ongoing Evaluations that Support Goals and Objectives in ACF Performance Plan

In December 2001, five-year results from the National Evaluation of Welfare-to-Work Strategies (NEWWS) were released. This study evaluated 11 programs in seven sites, comparing education-focused with employment-focused approaches. Studies are currently ongoing to examine the effectiveness of strategies to help welfare recipients retain and advance in employment; strategies to help those who are hard-to-employ enter and succeed in employment; and strategies to help rural residents move from welfare to work. Research and evaluation studies of child care services assist in promoting effective practices and provide a better understanding of child care supply, demand, unmet need, quality and cost for those transitioning from welfare to work. ACF has also initiated research to develop and evaluate strategies to promote child well-being through healthy marriage.

There is evaluative evidence that demonstrates the success of working through programs such as Head Start to prepare children for school. Results from the Family and Child Experiences Survey, a longitudinal study of a nationally representative sample of Head Start children, are beginning to show positive trends for Head Start children in cognitive and social skills, indicating learning readiness for kindergarten. The Early Head Start evaluation, completed in May 2002, demonstrated that Early Head Start improves some of the early building blocks for the development of literacy and school readiness.

The national survey of child and adolescent well-being (NSCAW) will provide valuable descriptive information including risk factors, service needs and services received on children and families who come into contact with the welfare system. Additionally, State and program administrative data are particularly useful in assessing trends and establishing targets for child welfare, abuse and neglect, early learning (Head Start) and child care.

In June, 2002, ACF released three-year results of the Early Head Start Impact Study, a random-assignment evaluation comparing outcomes for children and families in 17 Early Head Start programs with outcomes for children not participating in Early Head Start. Evaluations currently under way include the Head Start Impact Study, a nationwide random-assignment evaluation of Head Start; several partnerships between academic researchers and local Head Start programs to test program improvements; and an evaluation of child care subsidy strategies.

ONGOING EVALUATIONS THAT WILL INFORM PERFORMANCE MEASURES

Objective	Subject	Methodology
1.1 Increase Employment	Evaluation of Employment Retention and Advancement strategies; impact of welfare reform on child outcome measures; impact of rural welfare to work strategies; and the effectiveness of employment services for special populations	Impact Analyses (experimental design)
	Evaluation and demonstration of enhanced services for hard-to-employ parents	Experimental
2.1 Increase Independent Living	Evaluation of impact of Individual Development Accounts	Non-experimental
3.1 Increase Parental Responsibility	Evaluation of the role of both parents in providing financial and emotional support to their children; evaluation of strategies to improve child well-being by strengthening parental relationships and healthy marriage	Impact analyses and non-experimental methods
	Partners for Fragile Families evaluation	Process and impact evaluation
4.1 Increase affordable child care	Evaluation of Child Care Subsidy Strategies Multi-year, multi-site study evaluating effects of alternative State and community subsidy policies	Experimental
5.1 Healthy Development and Learning Readiness of Children	Continuation of National Study of Child Care for Low-Income Families; evaluation of child care subsidy strategies; grants to develop and test comprehensive school readiness strategies (joint with NICHD and Department of Education)	Surveys, site visits, impact analyses
5.2 Head Start	Continuing surveillance of the progress of Head Start children in social, cognitive and other domains (The Family and Child Experiences Survey)	Interviews, observations, assessments & surveys; impact analyses
	Head Start impact study examining the development and school-readiness of low-income children including language and literacy development.	Experimental
	Early Head Start follow-up study examining Early Head Start and control group children's progress through pre-kindergarten.	Experimental
	Early Childhood Longitudinal Studies with the Department of Education studying a cohort of Head Start children at kindergarten	Observations, interviews and

Objective	Subject	Methodology
	entry and continuing through the fifth grade.	data analysis
6.1 Safety, Permanency and Well-Being of Children and Youth	Continuation of national longitudinal study of child welfare that looks at the outcomes for families and children in areas of safety, permanency and child and family well-being.	Surveys, interviews, impact analyses
	Consortium for longitudinal studies of child maltreatment from time children are 4 years old until they reach adulthood.	Interviews and assessments Monitoring, State RO-CO partnership monitoring visits, pre-visit statewide assessments, analysis and use of existing data from NCANDS and AFCARS
	Systematic review of child welfare outcomes in areas of safety, permanency and child and family well-being.	Surveys, site visits, impact analyses
	Evaluation of technical assistance to grantees to improve local evaluations and encourage cross-site cooperation and consensus on data elements.	Contracts
	National evaluation of the impact of family preservation and support services	Meta-analysis of last 25 years of research and evaluation studies
6.5 Enhance child well-being by promoting healthy marriages and family formation and reducing out-of-wedlock pregnancies.	Develop evaluation design options for community marriage demonstrations.	Impact Study
	Evaluation of interventions for low-income unmarried parents	Experimental
	Multi-site evaluation and synthesis of Responsible Fatherhood Projects	Descriptive analysis using program and administration data and client interviews

A.6 FY 2001 PERFORMANCE DATA NOT REPORTED (PREVIOUSLY UNAVAILABLE)

Performance Goals	FY 01 Target	FY 01 Actual Performance	Reference
Developmental Disabilities-Employment			
1.3a. Achieve the targeted number of adults with developmental disabilities who obtain integrated jobs as a result of DD program intervention.	3,800	5,854	Pages 22-23
1.3b. Achieve the targeted number of businesses/employers that employ and support people with developmental disabilities as a result of DD program intervention.	1,350	1,813	
Refugee Resettlement			
1.4a. Increase the number of refugees entering employment through ACF-funded refugee employment services by at least five percent annually from FY 1997 actual performance.	56,885	45,893	Pages 28-30
1.4b. Increase the number of entered employments with health benefits available as a subset of full-time job placements by five percent annually from the FY 1997 actual performance.	30,613	27,270	
1.4c. Increase the number of refugee cash assistance cases closed due to employment by at least five percent annually as a subset of all entered employments from the FY 1997 actual performance.	18,163	14,223	
1.4d. Increase the number of 90-day job retentions as a subset of all entered employments by at least five percent annually from the FY 1997 actual performance.	41,824	31,137	
	9,504	13,882	

1.4e. Increase the number of refugees who enter employment through the Matching Grant program as a subset of all MG employable adults by at least five percent annually from the calendar year 1997 actual performance.	6,176	10,442	
1.4f. Increase the number of refugee families (cases) that are self-sufficient (not dependent on any cash assistance) within the first four months after arrival by at least four percent annually from the calendar year 1997 actual performance.			
Social Services Block Grant	2,399,827	3,150,776	Pages 39-40
1.5a. Increase by one percent the number of child recipients of day care services funded wholly or in part by SSBG funds over the previous year's performance.	339,253	260,937	
1.5b. Increase by one percent the number of adult recipients of home based services funded wholly or in part by SSBG funds over the previous year's performance.	313,075	912,661	
1.5c. Increase by one percent the number of adult recipients of special services for the disabled funded wholly or in part by SSBG funds over the previous year's performance.	1,302,895	1,411,427	
1.5d. Maintain the number of recipients of child protective services funded wholly or in part by SSBG funds.	1,321,736	1,439,530	
1.5e. Increase by one percent the number of recipients of information and referral services funded wholly or in part by SSBG funds over the previous year's performance.			
Developmental Disabilities-Housing	7,500	4,013	Page 45
2.1a. Achieve the targeted number of people with developmental disabilities owning or renting their own homes as a result of DD program intervention.			

Child Support			
3.1a. Increase the paternity establishment percentage (PEP)	96.5%	102%	Pages 53-54
3.1b. Increase the percentage of IV-D cases having support orders.	62%	66%	
3.1c. Increase the IV-D collection rate for current support.	54%	57%	
3.1d. Increase the percentage of paying cases among IV-D arrearage cases.	54.5%	59%	
3.1e. Increase the cost-effectiveness ratio (total dollars collected per \$1 of expenditures.)	\$4.00	\$4.18	
Child Care			
5.1a. Increase by one percent (95) the number of regulated child care centers and homes nationwide accredited by a nationally recognized early childhood development professional organization from the CY 2000 baseline.	9,630	9,237	Pages 76-77
5.1d. Maintain the number of States and Territories conducting unannounced inspections of regulated providers from the FY 2000 baseline.	43	47	
Head Start			
5.2a. Achieve at least an average 34 percent gain (12 scale points) in word knowledge for children completing the Head Start program.	10 (32%)	10 (32%)	Pages 82-85
5.2b. Achieve at least an average 52 percent gain (4 scale points) in mathematical skills for children completing the Head Start program.	3 (43%)	3 (43%)	
5.2c. Achieve at least an average 70	3.4 (70%)	2 (38%)	

percent gain (3.4 scale points) in letter identification for children completing the Head Start program.			
5.2d. Achieve at least an average 43 percent gain (1.24 scale points) in fine motor skills for children completing the Head Start program.	1.24 (43%)	1.05 (34%)	
5.2e. Achieve at least an average 14 percent gain (2 scale points) in social skills for children completing the Head Start program.	1.4 (10%)	1.9 (13%)	
5.2f. Achieve goal of at least 80 percent of children completing the Head Start program rated by parent as being in excellent or very good health.	80%	79%	
5.2g. Achieve goal of at least 70 percent the percentage of parents who report reading to child three times per week or more.	70%	69%	
5.2k. Maintain the average lead teacher score on an observational measure of teacher-child interaction.	73	72	
Child Welfare			
6.1b Decrease the percentage of children with substantiated reports of maltreatment that have a repeated substantiated report of maltreatment within six months.	7%	9%	Pages 96-98
6.1c. Maintain the percentage of children who exit the foster care system through reunification within one year of placement.	67%	68%	
6.1d Increase the percentage of children who exit care through adoption within two years of placement.	28%	23%	
6.1e. Maintain the percentage of children who exit foster care through guardianships within two years of placement.	67%	57%	

6.1f. Increase the number of adoptions.	51,000	50,000	
6.1h. For those children who had been in care less than 12 months, increase the percentage that had no more than two placement settings.	72%	60%	
Developmental Disabilities-Education			
6.2a. Increase the number of students with developmental disabilities who are served in more integrated/inclusive educational settings as a result of DD program intervention.	11,000	10,288	Page 106
Management			
8.1a2. Each ACF staff member participates in at least one Distance Learning or other training opportunity directly related to increasing his/her job skills.	100%	96%	Page 160
10.1a Develop and implement GATES II, which will capture and validate grant information submitted by grantees using the web.	FY 01: Gates II	Completed	Page 163

A.7 PERFORMANCE REPORT SUMMARY BY PROGRAM

Program	Total Measures	Measures Reported	Measures Met*	Unreported
TANF	FY 02: 5 FY 01: 5 FY 00: 5 FY 99: 2	FY 02: 0 FY 01: 2 FY 00: 5 FY 99: 2	FY 02: 5 FY 01: 1 FY 00: 4 FY 99: 1	FY 02: 5 FY 01: 3 FY 00: 0 FY 99: 0
DD	FY 02: 6 FY 01: 6 FY 00: 6 FY 99: 6	FY 02: 1 FY 01: 6 FY 00: 6 FY 99: 6	FY 02: 5 FY 01: 2 FY 00: 3 FY 99: 3	FY 02: 5 FY 01: 0 FY 00: 0 FY 99: 0
ORR	FY 02: 6 FY 01: 6 FY 00: 6 FY 99: 6	FY 02: 0 FY 01: 6 FY 00: 6 FY 99: 6	FY 02: 5 FY 01: 2 FY 00: 0 FY 99: 5	FY 02: 6 FY 01: 0 FY 00: 0 FY 99: 0
SSBG	FY 02: 5 FY 01: 5	FY 02: 0 FY 01: 5	FY 02: 5 FY 01: 4	FY 02: 5 FY 01: 0
OCSE	FY 02: 5 FY 01: 5 FY 00: 5 FY 99: 5	FY 02: 0 FY 01: 5 FY 00: 5 FY 99: 5	FY 02: 5 FY 01: 5 FY 00: 2 FY 99: 2	FY 02: 5 FY 01: 0 FY 00: 0 FY 99: 0
CHILD CARE	FY 02: 8 FY 01: 8 FY 00: 2	FY 02: 0 FY 01: 2 FY 00: 2	FY 02: 5 FY 01: 1 FY 00: 1	FY 02: 8 FY 01: 6 FY 00: 0
HEADSTART	FY 02: 14 FY 01: 13 FY 00: 5 FY 99: 6	FY 02: 14 FY 01: 13 FY 00: 5 FY 99: 6	FY 02: 4 FY 01: 3 FY 00: 3 FY 99: 3	FY 02: 0 FY 01: 0 FY 00: 0 FY 99: 0
CHILD WELFARE	FY 02: 6 FY 01: 6 FY 00: 10 FY 99: 9	FY 02: 0 FY 01: 6 FY 00: 10 FY 99: 9	FY 02: 5 FY 01: 1 FY 00: 4 FY 99: 2	FY 02: 6 FY 01: 0 FY 00: 0 FY 99: 0
YOUTH	FY 02: 3 [3] FY 01: 1 [3]** FY 00: 4 FY 99: 4	FY 02: 3 [3] FY 01: 1 FY 00: 4 FY 99: 4	FY 02: 3 FY 01: 1 FY 00: 1 FY 99: 1	FY 02: 0 FY 01: 0 FY 00: 0 FY 99: 0
CSBG	FY 02: 2 FY 01: 2 FY 00: 2 FY 99: 2	FY 02: 2 FY 01: 2 FY 00: 2 FY 99: 2	FY 02: 5 FY 01: 2 FY 00: 2 FY 99: 2	FY 02: 2 FY 01: 0 FY 00: 0 FY 99: 0
FVP	FY 02: 2 FY 01: 2 FY 00: 1 FY 99: 1	FY 02: 2 FY 01: 2 FY 00: 1 FY 99: 1	FY 02: 2 FY 01: 2 FY 00: 1 FY 99: 1	FY 02: 0 FY 01: 0 FY 00: 0 FY 99: 0
LIHEAP	FY 02: 2 FY 01: 2 FY 00: 2 FY 99: 2	FY 02: 0 FY 01: 2 FY 00: 2 FY 99: 2	FY 02: 5 FY 01: 2 FY 00: 2 FY 99: 0	FY 02: 2 FY 01: 0 FY 00: 0 FY 99: 0
ANA	FY 02: 2 FY 01: 2 FY 00: 2 FY 99: 2	FY 02: 2 FY 01: 2 FY 00: 2 FY 99: 2	FY 02: 2 FY 01: 2 FY 00: 2 FY 99: 2	FY 02: 0 FY 01: 0 FY 00: 0 FY 99: 0

Program	Total Measures	Measures Reported	Measures Met*	Unreported
ADMIN	FY 02: 4	FY 02: 1	FY 02: 1	FY 02: 3
	FY 01: 2	FY 01: 2	FY 01: 2	FY 01: 0
	FY 00: 2	FY 00: 2	FY 00: 1	FY 00: 0
	FY 99: 2	FY 99: 2	FY 99: 1	FY 99: 0

A.8 AVAILABILITY OF STATE AND GRANTEE ADMINISTRATIVE DATA

Program – Administrative Data System	Length of Time between end of Program Year and Submission of Data by State/Grantee	Length of Time between end of Program Year and Availability of Data	Reasons for Time Schedule	Strategy for Eliminating Time Delays where Appropriate
TANF participation rates: TANF Administrative Data	3 months	12 months (September)	The TANF statute allows States three months to report data at the end of each quarter. The additional time (9-12 months) is needed to ensure complete and accurate data reporting as well as final compilation and analysis of data.	FY 2000 was the first year of the new data reporting system. We expect that the timeliness and quality of the data will improve. We will continue to closely monitor State data transmission and provide TA as necessary.
TANF High Performance Bonus Measures	11 months to provide data for each quarter	15 months (December)	The data source for the work performance measures is the State employment wage records. Timing of employer reporting determines the availability of these data.	Beginning with the FY 2002 bonus (performance year FY 2001), we will have access to national wage records via the Office of Child Support Enforcement's new database and will match against these records to compile work performance data. Since Child Support relies on State reporting of these wage data, we do not believe time delays can be substantially reduced.
DD-Employment, Housing, and Education	3 months after end of fiscal year (January)	6 months (March)	All grantees submit their Program Performance Report (PPR) by January 1 of the next calendar year. The PPR's are reviewed by	AID provides ongoing training and technical assistance to grantees to ensure updated knowledge of electronic data

Program – Administrative Data System	Length of Time between end of Program Year and Submission of Data by State/Graantee	Length of Time between end of Program Year and Availability of Data	Reasons for Time Schedule	Strategy for Eliminating Time Delays where Appropriate
			respective regions and then forwarded to ADD office, where PPR's are stored in central database and reports are compiled.	submission and thorough understanding of data collection methods. Ongoing training and technical assistance improves timeliness and thoroughness of reports and provides a trained expert to respond to problem situations via email or phone.
DD – Health	3 months after end of fiscal year (January)	16 months (January)	Health data are collected by a technical assistance contract through manual system of reporting.	ADD plans to convert the manual data collection to an electronic collection system.
RR- State Administered	Fiscal Year -- 45 days after each quarter	7 months (April)	Quarterly reporting allows ORR to provide timely responses to issues that arise in the refugee program, to develop refugee assistance and services budget and update forecasting methodologies for determining the number of months ORR can provide cash assistance and medical assistance based on the number of refugees receiving or eligible to receive cash assistance. After receipt of the final report, ORR	ORR State analysts will make a more aggressive effort to contact ORR State coordinators when reports are past due. A written communication will be sent out from the ORR Director when reports are extremely delinquent.

Program – Administrative Data System	Length of Time between end of Program Year and Submission of Data by State/Grantee	Length of Time between end of Program Year and Availability of Data	Reasons for Time Schedule	Strategy for Eliminating Time Delays where Appropriate
RR – Matching Grant	Calendar Year – 4 month reporting cycles in May, September and January	7 months (July)	verifies and validates the grantee information. Statistical outcome reports are due at 4-month intervals. ORR uses these reports to provide managerial oversight of the program, develop policies for refugee assistance and services and direction and guidance to the States. The additional seven months after the end of the calendar year is necessary for ORR to validate and verify the data.	A written communication will be sent out from the ORR Director when reports are extremely delinquent.
SSBG	Within 6 months or when State submits its application for funding (which begins subsequent to the expiration of that 6-month period).	15 months (December)	Block Grant Regulations allow six months to report data at the end of the period covered by the report or at the time the State submits its application for funding which begins subsequent to the expiration of that 6 month period.	OCS is working to assure that the concerns expressed in the past about lack of information on the effectiveness of the SSBG in accomplishing its stated program goals will decrease. Work continues with States to improve reporting for services provided with these funds to improve the quality and timeliness of program information. All States were contacted to resolve any data questions and to

Program – Administrative Data System	Length of Time between end of Program Year and Submission of Data by State/Grantee	Length of Time between end of Program Year and Availability of Data	Reasons for Time Schedule	Strategy for Eliminating Time Delays where Appropriate
				confirm the State's methods for counting recipients, total expenditures, and TANF transfers.
Child Support Enforcement	3 months (December)	12 months (September)	OCSE allows States three months to report data at the end of the fiscal year. The additional nine months is needed to compile and analyze the data to ensure they are complete and accurate.	FY 1999 was the first year using the new reporting form. More States are transmitting their data electronically which will improve the timeliness and quality of the data. OCSE will continue to provide technical assistance.
Child Care – Fiscal Year Measures	3 months (December)	18 months (March)	The CCDBG statute allows States until 12/31 of any FY to submit their aggregate and final case level reports. Time is needed to verify and correct their submissions.	CCB continues to provide training and technical assistance to States experiencing reporting difficulties to improve timeliness, reduce errors, improve completeness, and encourage and facilitate development of State data systems.
Child Care – Calendar Year Measures	3 months (March)	12 months (December)	Data sources are external non-government agencies that report data on a calendar year basis.	NA
Head Start PIR measures	School Year - August	5 months (January)	Programs requested additional time. Time is needed to aggregate data.	NA
Head Start – FACES	Available on a 3-year cycle	2000/2001 cohort data will	Available on a 3-year cycle	NA

Program – Administrative Data System	Length of Time between end of Program Year and Submission of Data by State/Grantee	Length of Time between end of Program Year and Availability of Data	Reasons for Time Schedule	Strategy for Eliminating Time Delays where Appropriate
measures	– data submitted by evaluation contractor, yielding longitudinal data on HS program period and follow-up.	be available by December 2002	– data submitted by evaluation contractor.	
Child Welfare – measure 6.1f	Substantial amount of data are still being reported in May of the following year because 3 reporting periods are required to get one year's worth of data.	12 months (September)	Data are used to calculate adoption incentive awards, which are announced in the summer when total number of adoptions are announced. Data cannot be released until the announcement.	NA
Child Welfare – measure 6.1b	Voluntary reporting system – calendar year basis.	12 months (September)	Grantees submitting child abuse data require an extensive length of time to gather data.	NA
Child Welfare – remaining measures	November w/second submission due end of March for States penalized to submit for corrective actions.	9 months (June) -	States have 2-1/2 months after end of year to submit data and until March 31 to submit corrective actions. It takes two months for data to get to analysts from MIS processing units and for actual analysis.	NA
Youth	3 months Baselines for new measures will be established using a new data system.	6 - 9 months.	Community-based grantees do not always have the capacity and resources to submit data within 30 days, as required. Technical assistance is	Development of a new system for collecting and processing data will result in more complete reporting (the target for proportion of grantees reporting

Program – Administrative Data System	Length of Time between end of Program Year and Submission of Data by State/Grantee	Length of Time between end of Program Year and Availability of Data	Reasons for Time Schedule	Strategy for Eliminating Time Delays where Appropriate
			provided as needed. Additionally, see note at left.	correctly is 95 percent and above, in comparison with the 45-55 percent historical levels), as well as more accurate and timely national data.
CSBG	9 months (June)	15 months (December)	States are required to report the latest complete 12 months of CSBG data. The delay in reporting is the result of States and sub-grantees having different reporting periods. Under the CSBG Program, the reporting period coincides with the State fiscal year instead of the Federal fiscal year. Fifteen months are required to obtain, analyze and aggregate a CSBG report from all States.	The form used to collect the data was revised and has decreased the time required by States to compile individual State CSBG reports. This revised form has decreased the length of time between the end of the program year and the availability of data by six months to 15 months.
Native Americans	Grantees are on a 6-month reporting cycle from date of award. While ANA grants are awarded throughout the year, the majority are awarded at the end of the fiscal year making the final Progress Report & Financial Report (SF-269) due at the end of	During the third quarter (April-June)	Office of Grants Management OGM-00-03 and the Grants Administration Manual (GAM) 3.09.413 allows for timely submission of these reports every six months. The additional time is required to aggregate, verify and	NA

Program – Administrative Data System	Length of Time between end of Program Year and Submission of Data by State/Grantee	Length of Time between end of Program Year and Availability of Data	Reasons for Time Schedule	Strategy for Eliminating Time Delays where Appropriate
	October of the following year. Grantees are allowed 30 days to prepare and submit their final report.		analyze the data.	
LIHEAP		14 months (November 2002) for 2001 RECS and 2 months (November 2002) for the 2002 March CPS	OCS is using data from the Department of Energy's Residential Energy Consumption Survey (RECS) and the Bureau of Census March Current Population Survey (CPS) to track the LIHEAP measures. The March CPS is conducted annually and the RECS is conducted every four years.	NA
Administration – Training	3 months (December)	4 months (January)	Necessary to aggregate prior year data from 24 ACF components and regional offices	NA
Administration – GATES II and On-Line Data Collection System (OLDC)	9 months (June)	All data submitted to ACF via the GATES II interface will be immediately available to ACF organizations. The OLDC system is being pilot tested.	Delivery of production version of GATES II began in June 2002. The Beta version is being implemented for selected grantees to use the Web to submit financial reports during the second quarter of FY 2003.	The GATES II presents a data storage solution that provides live reporting on all ACF data collections. As data are supplied by grantees, approved data are then moved to data storage areas where report functions are capable of presenting the collection.

TUESDAY, MARCH 25, 2003.

ADMINISTRATION ON AGING

WITNESS

JOSEFINA G. CARBONELL, ASSISTANT SECRETARY FOR AGING

Mr. REGULA. We are going to recess the Committee for about 20 minutes. We have the Assistant Secretary on Aging. I don't know—you students don't think you will ever get old, but you might find that hearing a little bit interesting. In any event, you are welcome to stay. The Committee is in recess.

[Recess.]

Mr. REGULA. We are happy to have Ms. Carbonell from the Administration on Aging. It is a very important agency, because, hopefully, everybody gets an opportunity to use your services. And if we are fortunate, if the Secretary has his way, they will, because he is really pushing health.

I hope you have your mileage meters on.

Ms. CARBONELL. I wanted to give you that, Mr. Chairman. I think we have got—

Mr. REGULA. Well, he gave me one.

Ms. CARBONELL. Did he?

Mr. REGULA. Yes.

Ms. CARBONELL. I wanted to give it to Mr.—

Mr. REGULA. Matter of fact, I introduced him this morning at a meeting. He wanted to know whether or not I had my mileage meter on. Fortunately, I did.

Now, Ms. Roybal-Allard, you are going to have to walk everywhere so you get your 10,000 steps in every day.

Ms. ROYBAL-ALLARD. I have got to keep up with you, Mr. Chairman.

Mr. REGULA. Okay. We appreciate your summarization of your testimony.

Ms. CARBONELL. Thank you.

Good morning, Mr. Chairman and members of the Subcommittee. I am very pleased to be here with you today to discuss the President's fiscal year 2004 budget request of \$1.34 billion for the Administration on Aging.

AGING SERVICES

As a career-long advocate for older Americans, I have seen first-hand how our programs affect the lives of elderly individuals. Let me offer a few examples from our fiscal year 2001 program data.

We help seniors to maintain their independence by providing over 40 million rides—rides to doctors, senior centers and shopping—and over 13 million information and referral contacts; and we foster health by providing 250 million meals and 2.5 million

hours of nutrition education and counseling each year; we help prevent unwanted institutionalization through 10 million hours of homemaker services and 1.3 million hours of chore services.

But the Administration on Aging's programs do not just provide services. They are a catalyst for the vast array of Federal programs which focus on the needs of seniors. The President's budget makes a substantial investment in these programs.

Our fiscal year 2004 request will enable the Administration on Aging to support efforts to "rebalance" the long-term care system towards more care in the community, build partnerships which improve service coordination and promote healthy and active aging, and maintain support for core programs which have demonstrated their effectiveness in serving older Americans. And I would like to briefly discuss each of these areas.

"REBALANCING" LONG-TERM CARE

The Administration on Aging and our aging services network partners provide a foundation for the Department's efforts to rebalance the long-term care system toward relying less on institutional care and more on care in the community.

In addition to our dedicated staff, our programs are administered by 56 State Units on Aging, 655 Area Agencies on Aging, 243 Tribal organizations, over 29,000 local service providers and over half a million volunteers. This network is one of the Nation's largest providers of home- and community-based long-term care. Thirty-one State Units on Aging manage one or more Medicaid community-based care waivers, and many offices on aging have primary responsibility for their State's home- and community-based long-term care system and services.

The Administration on Aging is working to expand options for community-based care by collaborating with the Centers for Medicare and Medicaid Services and others in the Department to further involve the aging services network in the provision of a coordinated and integrated long-term care service system for disabled older adults. We are also working with other partners in the Department to identify State trends in long-term care, evaluate the local projects that deliver services to seniors where they live, and provide incentives to States to transfer individuals from institutional to community care.

Our fiscal year 2004 budget will support the aging network's role in long-term care. We will invest part of our \$28 million Program Innovations funding to establish Aging "One-Stop" Resource Centers. These centers will serve as a trusted resource for information on long-term care. They will also promote model programs which States can use to increase the community-based care choices and reduce nursing home care. Ultimately, this is what seniors prefer.

A number of States have already begun to do this with dramatic results, for example, the State of Washington. We have seen that in the State of Washington, they have increased the percentage of Medicaid funds spent on home- and community-based care from 22 percent to 48 percent over 7 years. This enabled them to serve twice as many seniors at home as in nursing homes at a lower net overall cost.

BUILDING PARTNERSHIPS

Expanding home- and community-based care options represents just one of the areas in which the Administration on Aging is collaborating with other agencies to better meet the needs of seniors. These partnerships, which will help providers to improve program performance and serve seniors better, include the following very critical initiatives:

The Aging States Project in which we are working with the Centers for Disease Control on health promotion activities targeting seniors;

The Nursing Home Quality Indicator Initiative in which we are working with CMS to train long-term care ombudsmen in communities to help consumers make informed uses of nursing home quality indicators and make better choices; and

An agreement that we have just recently signed with the Federal Transit Administration which will help us to increase coordination between our two departments—not only on the planning but also the funding of transportation services, a critical access to services for many of our seniors across communities in America.

In fiscal year 2004, the Administration on Aging will build on this track record by partnering with CDC and others in HHS to support the Department's \$125 million initiative to prevent and reduce the burden of chronic diseases. The Administration on Aging will work with our partners to develop critical activities focused on the needs of seniors and to implement them at the community level.

CORE PROGRAMS

Our budget request maintains support for our core programs. It provides \$718 million in grants to States for nutrition programs and supports the transfer of the Nutrition Services Incentive Program from the Department of Agriculture to the Administration on Aging. It also provides \$520 million in grants for States for supportive caregiver and preventive health services; \$26 million for services for Native Americans; and \$32 million to protect and support vulnerable populations and provide information and assistance to the aging network, seniors and their families and caregivers.

The effectiveness of these core programs is demonstrated in our GPRA performance plan and report, which accompanies our budget submission. Our report includes final performance data for fiscal year 2001. It also includes preliminary outcome data from six national surveys of major AoA services, and we are very happy to report on those. This data shows the effectiveness of our programs.

For example, I am pleased to say that since I submitted my written statement for the record to you, additional data has come in on the new caregiver program, and I can now say that States have reported serving over 325,000 caregivers across America, completely beyond our expectations and our goals.

Eighty-eight percent of caregivers reported that services enabled them to provide care longer than they otherwise could have; 85 percent of elders and family members seeking information and assistance from our aging network partners reported getting the infor-

mation they needed and expected; over 80 percent of and transportation recipients rated the service as excellent or very good.

CHALLENGES AND GOALS

I am very proud of the successes that the Administration on Aging and our aging network partners have achieved, but there is still much more to be done. We must continue to foster better access to an integrated array of health and social supports in the community. We must continue to ensure that elders are encouraged to live active and healthy lives, and it is never too late to start exercising.

We must continue to help families to care for their loved ones at home by supporting caregivers across America, and we must protect our most vulnerable seniors from abuse and exploitation, and promote effective and responsive management for all our programs.

I am committed to these goals, Mr. Chairman, and members of the Committee, and I look forward to working with each and every one of you to advance them in every possible way.

This concludes my testimony. I would be happy to respond to any questions that you might have.

[The information follows:]

1871

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION ON AGING

**House Committee on Appropriations
Subcommittee on Labor, Health and Human Services**

**Hearing on FY 2004 President's Budget
Tuesday, March 25, 2003
11:15 a.m. (Following ACF)**

PRINCIPAL WITNESS:

**Josefina G. Carbonell
Assistant Secretary for Aging
Administration on Aging**

ACCOMPANIED BY:

**Kerry N. Weems
Acting Assistant Secretary for Budget, Technology and Finance
Office of the Assistant Secretary for Budget, Technology and Finance**

Good morning, Mr. Chairman, and members of the Subcommittee. I am pleased to be here today to discuss the President's Fiscal Year (FY) 2004 budget request of \$1.344 billion in discretionary budget authority for the Administration on Aging (AoA).

Longer life expectancies and a growing senior population have increased the challenge of meeting the needs of older Americans. Today, almost one-sixth of our nation's population, over 46 million people, are age 60 and older. This includes 4.4 million seniors age 85 and older, a number that is projected to triple by the year 2030.

As a career-long advocate for older Americans, I have seen first hand the dramatic way in which AoA programs affect the lives of elderly individuals. For example, data for FY 2001 shows that we help seniors to maintain their independence by providing over 40 million rides and over 13 million information and referral contacts; we foster health by providing 250 million meals and 2.5 million hours of nutrition education and counseling each year; and we help prevent unwanted institutionalization through 10 million hours of homemaker services and 1.3 million hours of chore services.

But AoA programs do not just provide services. They serve as a catalyst for the vast array of programs across the Federal government which focus on meeting the needs of seniors and their families. The President's budget makes a substantial investment in these programs, and our FY 2004 request will enable AoA to make important contributions to initiatives that seek to expand choices and improve the quality of services. In FY 2004, we will support efforts to "rebalance" the system of long-term care toward providing greater options for seniors to receive care in the community, build partnerships with other agencies which improve coordination of services and promote

healthy and active aging, and maintain support for core home and community-based services which have demonstrated their effectiveness in serving older Americans.

SUPPORTING "REBALANCING" OF THE LONG-TERM CARE SYSTEM

AoA programs and the aging network's infrastructure provide a foundation for the Department's efforts to "rebalance" the system of long-term care toward relying less on institutional care and more on care in the community. We will use the resources of our complete network of State, local, and community service providers to do so. In addition to our Federal agency of 120 employees, our programs are administered by 56 State Units on Aging (SUA), 655 Area Agencies on Aging, and 243 Tribal organizations. They work with over 29,000 service providers and an estimated 500,000 volunteers across the country. And this does not include the estimated 23 million caregivers who help elderly family members, neighbors and friends every day.

The aging network is one of the nation's largest providers of home and community-based services and has a long history of partnering with other Federal, State, and local agencies to deliver long-term care services to seniors where they live. Thirty-one SUAs are responsible for managing one or more Medicaid waivers, and many States have designated their office on aging with lead responsibility for their home and community-based long-term care system.

AoA is actively working with other agencies to integrate service systems and develop information on options for expanding community-based care. We have worked with the Centers for Medicare and Medicaid Services (CMS) to make sure that older adults with disabilities were eligible for services under the Real Choice Systems Change

Grants initiative, which helps States to redirect and integrate their systems of care to respond to older people's preference for care in the community. We also worked to ensure that the SUAs were eligible to be designated as the lead agencies for their States' Systems Change grants and could participate in their development and implementation.

In addition, we are working with the Office of the Assistant Secretary for Planning and Evaluation and others to identify State trends in long-term care; develop case studies on flexible service models that have been used to create more community options for older people; and evaluate projects that promote "Aging In Place" by providing services to seniors where they live. This information will provide a valuable resource for Federal and State efforts to rebalance the long-term care system, including the Department's five year, \$1.75 billion "Money Follows the Individual" Rebalancing Demonstration, under which the Federal government will invest resources to provide incentives to States to transfer individuals from institutional to community care.

Our FY 2004 budget will help the aging network build the capacity to support this transformation through the establishment of Aging "One-Stop Shop" Centers. We will use part of our \$28 million request for Program Innovations, which promotes new and innovative approaches to meeting the needs of seniors, for this effort. By serving as a visible and trusted resource for information on long-term care, these Centers will help to eliminate the confusion and frustration that families now face when confronted with a range of overlapping programs and multiple service providers. The Centers will also provide information on best-practices and model programs which States can use to reduce nursing home care and increase community-based care choices, which is what seniors prefer. A number of States, including Colorado, Oregon, Texas, Vermont, Washington,

and Wisconsin, have already begun to implement these changes and have seen dramatic results. For example, the State of Washington increased the percentage of its Medicaid long-term care funds spent on home and community-based care from 22 percent to 48 percent over seven years, enabling it to serve twice as many seniors at home as in nursing homes, at a lower net overall cost.

BUILDING PARTNERSHIPS TO SERVE PEOPLE BETTER

Our efforts to expand options for home and community-based care represent just one of the areas in which AoA is collaborating with other agencies and levels of government to better meet the needs of seniors. These partnerships will help providers pool resources and coordinate services so that they can improve program performance and serve seniors better. For example:

- AoA is working with the Centers for Disease Control and Prevention (CDC) on the Aging States Project, by pooling resources to support health promotion projects targeting seniors which promote physical activity, walking programs, improved diet, and healthy lifestyle choices.
- We are collaborating with CMS to capitalize on the vast experience of the nation's over 13,000 volunteer ombudsmen by involving them in the Nursing Home Quality Indicator Initiative (QI). Ombudsmen were trained to provide information and assistance on how quality indicators can help consumers make informed nursing home placement and care decisions.
- AoA is partnering with the Federal Transit Administration (FTA) to increase coordination of planning and funding for transportation services. Data shows

that one-third of elders receiving transportation services rely on it for virtually all of their transportation needs. This equates to roughly one million elders who in all likelihood would become homebound were it not for this service.

AoA and FTA will work to disseminate information on promising practices and conduct regional technical assistance sessions to promote models and new approaches for coordinating transportation resources.

In FY 2004, AoA will build on this track record of successful collaborations by partnering with CDC and other HHS agencies to support the Department's \$125 million Steps to a Healthier U.S. Initiative, the goal of which is to help Americans live longer, better, and healthier lives. At the heart of this program lie both personal responsibility for the lifestyle choices Americans make and social responsibility to ensure that policy makers support programs that foster healthy behaviors and prevent disease. This initiative will focus on diabetes, obesity, asthma, heart disease and stroke, cancer and the lifestyle choices including poor nutrition, physical inactivity, tobacco use, and youth risk-taking. Many of these diseases have a significant impact on older Americans: between 15 and 23 percent of adults over 60 are obese; diabetes is the sixth leading cause of death for persons age 65 years or older; and 2 million people age 65 and older have asthma. AoA will work with our partners in this initiative to develop activities focused on the unique needs of seniors.

MAINTAINING SUPPORT FOR EFFECTIVE CORE PROGRAMS

The FY 2004 request provides funding for most of our core programs at levels which are about equal to both FY 2002 and FY 2003, including over \$718 million for

nutrition programs which provide meals to seniors at home and in congregate settings. These programs provided over 250 million meals to seniors in FY 2001, and preliminary outcome survey data shows that over 75 percent of elderly meal recipients are at “high nutritional risk”. This request includes funding for the Nutrition Services Incentive Program (NSIP) which was transferred from the Department of Agriculture to AoA in the FY 2003 appropriations legislation. In FY 2004, NSIP funding will continue to be available exclusively for meals, States will retain the option to receive commodities in lieu of cash, and funds will continue to be distributed based on the number of meals served in the prior year.

For other core programs, our budget includes \$520 million for grants to States for home and community-based supportive services, including services to family caregivers and preventive health services. It allocates over \$26 million to grants for nutrition and supportive services for Native Americans. And it provides almost \$32 million for activities which protect and support vulnerable populations – including persons with Alzheimer’s disease – and provide information and assistance to the aging network, seniors, and their families.

The effectiveness of our core programs is demonstrated in our Government Performance and Results Act performance report for FY 2002 and plan for FY 2003 and FY 2004, which accompanies our budget submission. We agree with the importance the Congress and the Administration have placed on performance measures and have invested in national data collection to provide you with that valuable information.

I am pleased to say that our report includes final performance data for FY 2001, including data for the family caregiver program. Our report also includes preliminary

outcome data from six national surveys of major AoA services. This data shows that AoA programs continue to be effective in meeting the needs of seniors and producing the results sought by the Older Americans Act. For example:

- States have reported serving over 275,000 caregivers, exceeding our proposed target of 250,000. Eighty-eight percent of caregivers reported that services enabled them to provide care longer than they otherwise could have.
- 85 percent of elders and family members seeking information from the network reported getting the information they needed and expected.
- Over 80 percent of transportation recipients rated the service as excellent or very good, and 76 percent said they would recommend it to their friends.

FOCUS ON THE CHALLENGE OF AN AGING POPULATION

Finally, we are requesting \$2.8 million in three-year funding to cover start-up costs for a White House Conference on Aging. Historically, these conferences have served as catalysts for the development of aging policy and led to improvements in the programs which assist seniors and their families. In fact, the development of many of the programs which have fostered a better quality of life for older Americans were prompted by the recommendations of prior White House Conferences on Aging. This conference would be the first of the 21st century and the fifth overall.

I am proud of the successes that AoA and the aging network have achieved, but there is still more to be done. We must continue to foster better access to an integrated array of health and social supports, ensure that elders are encouraged to live active and healthy lives, help families to care for their loved ones at home, protect our most

vulnerable seniors from abuse and exploitation, and promote effective and responsive management for all our programs. I am committed to these goals and I look forward to working with the members of this Committee to advance them in every possible way.

Thank you for inviting me here to address you this morning. I am happy to answer any questions you may have.

JOSEFINA G. CARBONELL**ASSISTANT SECRETARY FOR AGING
DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING**

Josefina G. Carbonell was appointed by the President and sworn in as Assistant Secretary for Aging at the U.S. Department of Health and Human Services (HHS) on August 8, 2001.

As the Assistant Secretary for Aging, Ms. Carbonell is a strong advocate for older Americans and their concerns. She is dedicated to preparing America to meet the challenges and to maximize the opportunities presented by the longevity of its people. Her priorities include ensuring that Administration on Aging and the Aging Services Network continue to play a leadership role in shaping our evolving health and long term care system on behalf of older people; helping older people to stay active and healthy; supporting families in their efforts to care for their loved ones at home and in the community; and ensuring the rights of older people.

Prior to joining HHS, Ms. Carbonell was President and CEO of the largest Hispanic geriatric health and human service organization in the nation – Little Havana Activities & Nutrition Centers (LHANC) in Dade County, Florida. Through her leadership, coupled with sound management skills, she helped establish this successful network of 21 sites, serving more than 55,000 registered clients.

Ms. Carbonell is nationally recognized as a person of compassion and action and is the recipient of numerous awards, including one of the Hispanic Business 100 Most Influential Hispanics in 2002. She has also been the recipient of the 2001 Claude Pepper Community Service Award, the 1997 Social Security Administration Commissioner's Team Award, the 1997 United Way Monsignor Bryan Walsh Outstanding Human Service Award, the 1995 National Alliance for Hispanic Health Community Service Award, the Miami Herald Charles Whited Spirit of Excellence Award in 1993, and the 1992 Miami Citizen of the Year Award. She has served on numerous boards, including Excellence in Long Term Care, Aging with Dignity, the National Coalition of Hispanic Health and Human Services Organization and the National Committee to Preserve Social Security and Medicare.

Ms. Carbonell attended Florida International University and was the recipient of a fellowship in health management at the John F. Kennedy School of Government at Harvard University, and is an alumnus of the Program for Senior Executives in State and Local Government.

Born in Cuba, Josefina Carbonell is a devoted daughter to her parents and proud mother to her son, Alfredo, a physician practicing in North Carolina.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
BIOGRAPHICAL SKETCH

NAME: Kerry N. Weems

POSITION: Deputy Assistant Secretary for Budget

BIRTHPLACE: Portales, New Mexico

EDUCATION: B.A., Philosophy, New Mexico State University, 1978
BBA, Management, New Mexico State University, 1978
MBA, University of New Mexico, 1981

EXPERIENCE:

January 24-Present Acting Assistant Secretary for Budget, Technology and Finance

June 2002- Present Deputy Assistant Secretary for Budget, HHS

2001 - 2002 Acting Deputy Assistant Secretary for Budget, HHS

1996 - 2002 Director, Division of Budget Policy, Execution and Management, HHS

1991 - 1996 Chief, Budget Planning Branch, HHS

1988 - 1991 Program Analyst, Office of Budget, HHS

1983 - 1988 Program and Budget Analyst, HHS
(Social Security Administration)

1981 - 1983 Staff Member, United States Senate

HONORS AND AWARDS:

2001 Presidential Rank Award

1995 Secretary's Distinguished Service Award

1993 HHS Senior Management Citation

INTERNATIONAL AGING

Mr. REGULA. Well, thank you.

I would be curious, do other countries around the world provide these kinds of services to their aging population?

Ms. CARBONELL. Having led the U.S. delegation to the World Assembly on Aging this past year in Madrid—April this past year—we were able to not only further an international agenda on positive aging, safety and community supports for aging, but we were able to share with our international colleagues in the area of aging on how the United States has taken extensive efforts to provide community supports in community settings.

So one of the greatest assets that we have—the Administration on Aging and Older Americans Act programs—funding for these programs has created the whole basis of the home- and community-based care network that, in some instances, has not been really extensively developed in other parts of the world.

Mr. REGULA. So this country probably leads the way in what it does for the aging?

Ms. CARBONELL. We are leading the way in our investments. And particularly in the fiscal year 2004 budget, the President has laid out some historical investments in aging programs. In our area, which is improvement in giving people the choice to remain at home, which is ultimately what they wish to do, we are working to rebalance from institutional care to home-based care.

We are investing in the New Freedom Initiative where we are trying to tear down barriers to independent living that keep both younger disabled individuals and older disabled individuals from remaining independent. And we are making tremendous advances in health sciences research, thanks to the resources that have been identified and placed at NIH. At the National Institute on Aging. We know that with exercise, with proper nutrition, with intervention activities to keep people healthy and to do better at prevention, we can not only extend life but improve the quality of life by reducing chronic diseases and disability.

AGING RESEARCH

Mr. REGULA. Do you communicate with NIH, and do they do research on programs that are important to seniors? Of course, that would include, in addition to medical care, nutrition, et cetera.

Ms. CARBONELL. Absolutely. All of the research that is done at the National Institutes of Health, including the National Institute on Aging and others—we put the results of the best research and its outcomes into play in our programs. That means that all of the best scientific research is put into action in the community-based programs that we administer across this country. And we are very proud of the working relationship that we have with the National Institutes of Health and most importantly, across the entire department. Having come from the community and having struggled at the community level to try to manage different funding sources to ultimately serve consumers better, it has been so rewarding to work for someone like Secretary Thompson, who is committed to making sure that we work in a collaborative and coordinated fashion, which ultimately will facilitate those services at the local level.

PUBLIC OUTREACH

Mr. REGULA. How does the aging public find out about your services?

Ms. CARBONELL. We have an extensive array of outreach services. There are both outreach services and information and referral services, but we have made some substantial investments in this past year and in this budget to improve our web technology at the Administration on Aging web site. We have also developed our communication abilities by restructuring our agency. One of the major services within the Older Americans Act is giving people information and access to resources and community programs. So we have taken a real step in improving our ability at the Federal level, our ability to collaborate with other entities and with other agencies in the Department to make sure that that information—the best information that we have—is then transferred to the field at the State and local level.

We have the Eldercare Locator number, which is a 1-800 number that is available nationally. And we partner with all of our local providers. Anyone at any point in time can call the Eldercare Locator and can access services for themselves or for their loved ones in a specific ZIP code area or city or community across this country.

We have invested in public service announcements and video initiatives that have been launched on a national basis with tie-ins to communities, and of course we have got a strong local community aging network that has both the information referral lines and the elder help lines set up both at the State level and at the local level to be able to respond.

The Family Caregivers Program also gave us the ability to extend our information network to include a different clientele, the caregiver who is caring for a loved one, and we are able to not only give them information but to really chart a route to assistance and access to services.

Mr. REGULA. So you have the programs that a caregiver could use to or learn ways to be better able to serve the aging?

Ms. CARBONELL. Absolutely. As a matter of fact, we have reached 325,000 caregivers. Not only is the Caregiver Program a new program to develop and create the infrastructure in States and local communities to serve caregivers and their families, but the program also is able to give increased information capacity. And we are very pleased to report the numbers that have come in our data. We have provided thousands of people with information assistance, and we continue to develop and work upon that capacity.

COMMUNITY-BASED CARE

Mr. REGULA. I assume your services are substantial in allowing people to stay in their own homes versus institutionalization?

Ms. CARBONELL. Yes. As I said at the beginning, I think having served at the community level and now being at the head of the Administration on Aging has allowed me to see how the aging network has developed the capacity at the local level to be the alternative to institutionalization. Our data and the outcome measures and the surveys that we just conducted are really giving us the in-

formation, the outcomes that we knew that we were getting, but we didn't have the data before to prove it.

SENIOR CENTERS

Mr. REGULA. Do you do any funding of senior centers?

Ms. CARBONELL. Yes. We have over 29,000 community providers at the local level. Many of them are what we call senior centers that serve as focal points for the community. These Senior Centers help to divert people from institutional care, and provide community care in adult day care settings, do prevention, exercise and activities within the community.

INSTITUTIONAL CARE

Mr. REGULA. Do you do any interface with the industry that provides the rest homes, for lack of a better term? Do you interface with them in some of the services that you can provide for those that are in an institution?

Ms. CARBONELL. Yes. One of the greatest success stories that we have is not only the ombudsmen program—this serves seniors that are in institutional care, both in nursing homes and assisted living facilities.

Mr. REGULA. I am familiar with that.

Ms. CARBONELL. And they are terrific. I mean, we have over 8,000 certified ombudsmen working in the communities, and we are very pleased with the work that we just recently did in our collaboration effort with the Centers for Medicare and Medicaid Services, as they improve the quality outcome indicators (QIO) that they develop both for nursing homes and then, most recently, for home health care.

And in our Ombudsman Program, we work together with CMS to train the ombudsmen, all of them, not only in the six pilot States where this was launched, but to take this program on a national basis. This ensures that the Ombudsman Program and the services and the volunteers that are working in this program work in conjunction with the CMS QIO initiatives in each community, and most importantly, continue to support and inform families in making better, informed choices on the ratings of the nursing home and assisted living facilities.

AGING "ONE-STOP SHOP" CENTERS

Mr. REGULA. Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Thank you, Mr. Chairman.

Ms. Carbonell, one of the things that I am interested in is the "One-Stop Shop" Centers that you have talked about, because I know from my own personal experience how frustrating it is for families to deal with the range of overlapping programs and multiple service providers.

Can you tell us more about the models that you are using for this program, what you hope to accomplish and whether or not—are these demonstration models, or are these—is this a program that you are trying to establish system-wide throughout the Nation?

Ms. CARBONELL. The Older Americans Act and the programs that we administer at the local level have been really the foundation for

home- and community-based care. As the Department and the President move forward in being able to give seniors and older Americans better choices to remain at home, our commitment is to work together with the Centers for Medicare and Medicaid Services in the rebalancing of the long-term care system.

What that means is that our role is, number one, to support it, and to serve as the foundation; and we will invest Program Innovation grant dollars to be able to test models that either exist in the community or are in the process of being developed in communities.

A percentage of our community providers are already integrated and are managing Older Americans Act programs and also serving as the lead agency for some of the Medicaid waivers at the State level. We want to fund and to be able to improve upon the capacity of our local aging network to move a step further. The "one-stop" concept means seniors or their family caregivers can reach no wrong door when trying to get services.

Having struggled with caregiving myself at the community level, many of us in our respective communities know how people have to go to two and three places to finally get some kind of substantial information that would assist them or give them access to those kinds of resources. We want to be able to work together and to have our aging network make sure that they partner with Medicaid Offices. That means investing dollars to improve our aging network's capacity to work together with the Medicaid programs, to be able to be seamless to the public at large and to better serve individuals.

So we envision the ability to put out competitive grants to States to give them the opportunity—since Medicaid programs are State-funded programs, and our Older Americans Act programs are also State-funded programs—to develop the capacity to begin to shift some of the institutional care clients back into the community. We want to foster that, and we want to offer the opportunity to work together with CMS to be able to do that.

Ms. ROYBAL-ALLARD. Now, when would these grants be made available?

Ms. CARBONELL. The first set of grants will roll out in fiscal year 2003, and we have proposed in fiscal year 2004 to continue to do that. Grants will roll out in a couple of months, and we are looking at maybe 10 to 14 States who are willing to apply for these kinds of competitive grants. And the grants will be going out together with grants from CMS.

That means that CMS has a set of key programs that they are investing in both rebalancing and Real Choice Grants, which have the ability to assist States to improve their capacity to shift their systems from institutional care to home- and community-based care. And what these monies will do jointly at the Federal level is give an opportunity for States to do the same thing, to be able to not only join the programs, but also join the resources to ultimately serve seniors more effectively.

Ms. ROYBAL-ALLARD. Okay. And what is the level of funding of these grants?

Ms. CARBONELL. The current level of funding that will go out in the initial grant is up to \$10 million.

PROGRAM MODELS

Ms. ROYBAL-ALLARD. Also I understand that you are going to be in southern California sometime this month or next month.

Ms. CARBONELL. At the end of the month.

Ms. ROYBAL-ALLARD. I don't know whether or not you are familiar with the Scan Health Plan that is being demonstrated in California—or in southern California. It is very similar to many of the services that you are offering. The goal, of course, is to keep seniors at home while they can receive all the various types of services that they need.

Have you looked at the social HMOs as a prototype for care that would be delivered to the elderly, and have you participated in any of the evaluations of these comprehensive services? Because I know there are differences of opinion as to whether or not they accomplish their goal.

Ms. CARBONELL. Our proposal and the proposal that we are working on in fiscal year 2003, and then through this request in fiscal year 2004, is to really invest in our aging network partners; that means our States, our area agencies on aging, our local community providers. And we do not want to define what the system is or who that should be. We want to leave it open to the States, and the Governors to decide in that specific State, which is the best system, which would be the best lead agency to be identified.

I can tell you that we went across the country, and one of the sites that we visited is the San Diego pilot site that is being developed right now in conjunction not only with State dollars, but some of the Real Choice grant dollars that came in from the Federal Government. And we went to Wisconsin, which Secretary Thompson looked at. We went to Arkansas. We have gone across the country to look at different models. We were in Ohio looking at the program for long-term care and the improvement in the home- and community-based care. So we went to different parts of the country and looked at all models.

We don't want to define a specific model. We want to define just a core set of values, which means giving consumers more choices and opportunities to have a say in their care. We want to give the opportunity, ultimately, for people to remain at home, and we are investing—that includes CMS in their waivers, their choice grants and their rebalancing. They are investing dollars to reimburse States at a higher level or 100 percent in the \$1.75 billion request for rebalancing. It is to give States incentives and to reimburse States 100 percent by rebalancing their long-term care systems from institutional care to home- and community-based care.

So it is really a historic moment in which our partners in the aging network, which serve as a base for community-based care, partner with CMS, which provides the funding for—in this instance Medicaid—to be able to make a more constructive and more efficient system where people can access—have better choices of community-based care and, most importantly, have a role in the consumer-directed care arena.

So we are not looking at any model in particular. We want the States and the local communities to identify what that model is.

PROGRAM EVALUATION

Ms. ROYBAL-ALLARD. Can I just ask one more question, Mr. Chairman?

So as you are going around and looking at those different demonstration projects, you do not see a role in critiquing these projects at all, so that perhaps they can work better and meet the criteria of CMS? Are you leaving the critique entirely up to the State, or are you giving input as to what you see?

Ms. CARBONELL. There is a set of core values that will go along with this set of competitive grants, and first of all, it is the commitment from the State to not just do this because they have funding for it at the Federal level, but to do it because there is a commitment from the State to begin to shift some of the long-term care.

We know and data has shown us that in those instances where the States invest more dollars in home- and community-based care, not only are States serving more people, have the capacity to serve more people, but they are serving at a net cost that is much lower than institutional care. And ultimately, they are giving people what they want, which is to remain at home. So we need to continue to build the infrastructure and capacity at the local level, to be able to shift people into home- and community-based care.

So we are looking to States. We have models, and a part of the money will be used also for research in conjunction with the Secretary's planning and evaluation unit, to address not only research but the best data available out of the outcomes.

Ms. ROYBAL-ALLARD. So there is a set of criteria that——.

Ms. CARBONELL. Yes.

Ms. ROYBAL-ALLARD. Okay. Thank you. Thank you.

Mr. REGULA. Thank you very much for appearing today. I think this is extremely important to the aging population, and it is going to grow. And anything you can do that helps them to stay in their own home, I think is a great contribution to their quality of life. So we wish you well in your service to them. I know we have an active group out in my area.

Ms. CARBONELL. Thank you. Thank you, Mr. Chairman.

Mr. REGULA. The committee is adjourned.

[The following questions were submitted to be answered for the record:]

DEMAND FOR SERVICES

Mr. Regula: With the life expectancy of Americans increasing each year, do you anticipate greater demand for the kinds of services being offered through the grants funded by AoA in the coming years?

Ms. Carbonell: The "baby boom" generation will begin to become eligible for the services that AoA provides beginning in the latter part of this decade. The aging of the baby boom and increasing life expectancy is very likely in the future to increase the demand for AoA services. In the short run, however, just as life expectancy is increasing, so also is the health and strength of elderly individuals. Through our focus on preventive health activities, we hope to expand on this trend and thereby help to reduce the need for our more intensive interventions. At the same time, we recognize that significant growth will continue to occur in the very old segment of the elderly population, among those age 85 and older. To meet the preference of this group to remain independent and in their own homes and communities for as long as possible, the Department is working to rebalance the long-term care system. This rebalancing initiative will enable more older Americans to stay at home longer rather than having to move to an assisted care facility or a similar setting. In future years, this rebalancing could have an impact on the demand for the kinds of services being offered through the grants that AoA funds.

Mr. Regula: What percentage of the population over 60 do you currently serve?

Ms. Carbonell: AoA provides services to approximately seven million seniors age 60 and over, including three million registered clients who receive intensive in-home services. This represents approximately 15 percent of the population age 60 and over.

Mr. Regula: Do you hope to expand your programs so that more seniors may be able to stay at home longer rather than moving to an assisted care facility or a similar setting?

Ms. Carbonell: One of the major themes in our FY 2004 budget request is to support the Department's efforts to "rebalance" the long-term care system toward community-based services rather than institutional settings. This effort is consistent with the strategic priorities I have set out for AoA, which include making it easier for seniors to access an integrated array of health and long-term care services and to help more families to care for their loved ones at home and in the community. Data show this is what seniors prefer. For example, in a 2000 AARP survey, 82% of respondents said that if they need help caring for themselves they would prefer not to move from their current homes.

AoA is involved in a variety of activities which will support this "rebalancing" effort. We are working with the Center for Medicare and Medicaid Services (CMS) to involve State Units on Aging in planning and implementing the Real Choice Systems Change grants, and to ensure that disabled older adults are eligible for services. We are also working with the Assistant Secretary for Planning and Evaluation, CMS, and others to evaluate State trends in long-term care and local "Aging in Place" projects that deliver services to seniors where they live.

In addition, starting in FY 2003, AoA will help the aging network build the capacity to support the "rebalancing" effort through the establishment, in partnership with CMS, of Aging "One-Stop Shop" Resource Centers. These centers will provide information to seniors and families on long-term care options, help streamline and coordinate access to services, and promote best practices and model programs which States can use to reduce nursing home care and increase community-based care choices.

LONG-TERM CARE OMBUDSMEN

Mr. Regula: What percentage of the total number of nursing facilities do the long-term care ombudsmen visit each year?

Ms. Carbonell: In FY 2001, the latest year for which we have ombudsman program data, ombudsmen visited 85.4 percent of all nursing facilities on a regular basis, as opposed to in response to a complaint. "Regular basis" is defined as at least quarterly.

"REBALANCING" THE LONG-TERM CARE SYSTEM

Mr. Regula: Please tell us more about what you mean to do to "rebalance" the long-term care system.

Ms. Carbonell: The "rebalancing" initiative reflects the recognition that when given the choice, seniors prefer to receive care at home and in the community as opposed to in nursing homes and other institutional settings. AoA and its aging services network are key partners in the Department's "rebalancing" initiative and we are working on a number of fronts to support it.

AoA and the infrastructure of its aging services network provide a foundation for "rebalancing" the long-term care system toward care in the community. This network is one of the nation's largest providers of home and community-based care services. Thirty-one State Units on Aging manage one or more of their States' Medicaid community-based care waivers. Many States have also designated lead responsibility for their home and community-based long-term care system to their State aging office.

AoA is actively partnering with other agencies to integrate service systems and expand options for community-based care. We are collaborating with the Center for Medicare and Medicaid Services (CMS) to involve State Units on Aging in planning and implementing the Real Choice Systems Change grants, and to ensure that disabled older adults are eligible for services. We are also working with the Assistant Secretary for Planning and Evaluation, CMS, and others to evaluate State trends in long-term care and local "Aging in Place" projects that deliver services to seniors where they live.

Beginning in FY 2003, AoA will help the aging network build the capacity to support this transformation in long-term care through the establishment of Aging "One-Stop Shop" Resource Centers. These centers will serve as visible and trusted resources for seniors and families looking for information on long-term care options and help streamline and coordinate access to services at the local level. These centers will also promote best practices and model programs which States can use to reduce nursing home care and increase community-based care choices. AoA will work in partnership with CMS to fund, select, monitor, and evaluate these projects.

HEALTHCARE SERVICE DELIVERY SYSTEM

Mr. Regula: Last week during the hearing with Secretary Thompson, we discussed the need to move to a more seamless healthcare service delivery system. How does the Administration on Aging plan to support this goal?

Ms. Carbonell: A new discretionary grant activity administered by the Administration on Aging will support the development of consumer-centered "one-stop shop" entry points into the long-term care system at the community level. These resource centers will serve individuals who need long-term care, their family caregivers, and those planning for future long-term care needs. Centers will provide information on the range of health services available through Medicare, Medicaid and State-run programs as well as on social supports. They will also serve as a resource for health and long-term care professionals and others who provide services to the elderly and to people with disabilities.

These "one-stop shops" are a key element of a consumer-centered system of long-term care. In many communities, long-term care services are supported by numerous funding streams, administered by multiple agencies, and have complex, fragmented and often duplicative intake, assessment and eligibility functions. Figuring out how to obtain services is difficult both for persons who qualify for publicly funded supports and for those who can pay privately. These barriers lead to institutional long-term care as the default outcome. A single, integrated system of access for all persons seeking assistance on long term care matters will minimize confusion, support consumer choice and informed decision-making, improve a State's ability to monitor program quality and cost through centralized data collection and evaluation, enable policy makers to respond to system problems and improve services, and limit unnecessary institutionalization and its associated costs.

AoA will also continue to actively partner with other agencies to integrate the health and social services systems and expand options for community-based care. We are collaborating with the Center for Medicare and Medicaid Services (CMS) to involve State Units on Aging in planning and implementing the Real Choice Systems Change grants, and to ensure that disabled older adults are eligible for services. We are also working with the Assistant Secretary for Planning and Evaluation, CMS, and others to evaluate State trends in long-term care and local "Aging in Place" projects that deliver services to seniors where they live.

Mr. Regula: What kinds of activities are funded through the \$5 million medication management, screening and education earmark in the Preventive Health Services program?

Ms. Carbonell: AoA's Preventive Health Services program provides States and communities with the flexibility to help support the health promotion and disease prevention needs of seniors. Included in this program is an earmark for activities regarding medication management, screening, and education to prevent incorrect medication and adverse drug reactions. Medication management among older adults is a growing issue due to the increasing availability of improved and stronger medicines and because of the physiological changes that occur with aging. Medication management services help older adults learn more about important medication issues, including preventing interactions between drugs, following usage instructions, keeping track of medication regimens and getting professional advice. One activity at senior centers is the brown bag medicine programs where seniors come into the center, bring all their medicines including over the counter medicines and have a pharmacist review the contents of their bag. This is a very popular program with the seniors.

Mr. Regula: What more can be done to ensure that the population over 60 is receiving the kind of healthcare needed to allow them to "age in place"?

Ms. Carbonell: One of the challenges we face is ensuring that seniors with chronic conditions who need health and long-term care are able to receive the care in the least restrictive setting. The Administration on Aging is promoting the development of "one-stop shop" resource centers to provide assistance to older adults at these critical moments in their lives. These resource centers, which will be located in our communities, will provide information and assistance in accessing a wide range of health and long-term care services needed by many of our nation's elderly. The goal of this program is to empower consumers to make informed choices by providing them with accurate information and counseling and streamlining access to services. The resource centers will provide "one-stop shopping" to the general public with a focus on long-term care issues affecting people with disabilities of any age and their families. The Centers will be welcoming and convenient places to get information, advice, and access to appropriate services regardless of one's economic status, payer status, or type of disability. The Administration on Aging believes that improving the up-front system of access to services will significantly impact the ability of older adults to receive appropriate and timely health care.

"MONEY FOLLOWS THE INDIVIDUAL" REBALANCING DEMONSTRATION

Mr. Regula: What kinds of activities will be undertaken in the "Money Follows the Individual" Rebalancing Demonstration program? What will be AoA's role?

Ms. Carbonell: The Centers for Medicare and Medicaid Services (CMS) is leading the Department's effort on the "Money Follows the Individual" Rebalancing Demonstration Program, which seeks to promote the use of at-home care as an alternative to nursing homes for elderly and disabled Americans. Under this five-year, \$1.75 billion demonstration project, the Federal government will fully reimburse States for one year of Medicaid home and community-based services for individuals who move from institutions into at-home care. After this initial year, States will be responsible for matching the Federal government payment at their respective rates.

The AoA is actively supporting the overall initiative and is involved in many related activities. AoA is partnering with CMS to build the aging services network's capacity to support this transformation in long-term care through the establishment of "one-stop shop" resource centers for long-term care. AoA continues to work with CMS to ensure that the aging network is involved in the implementation of the Real Choice Systems Change grants, a key component of the systems development that is necessary to lay the groundwork for the Rebalancing Demonstration. Likewise, AoA will work with CMS to ensure that the aging network is involved in the implementation of this demonstration program in order to ensure that older adults fully benefit from its opportunities.

STEPS TO A HEALTHIER US

Mr. Regula: How is AoA integrating the Secretary's initiative, Steps to a Healthier US, into its programs?

Ms. Carbonell: AoA has initiated the USA on the Move: Steps to Healthy Aging program in concert with the Secretary's Steps to a HealthierUS. AoA's program is a two-part program focusing on eating better and moving more. The Steps to Healthy Aging: Moving More uses electronic step counters to monitor and increase physical activity in older adults. The second part of the program promotes eating better by making healthy choices. A Guidebook for Community Programs will be available in late summer 2003 and will show how to plan, design, implement and evaluate a community-based walking program for individuals and groups. It will include program materials as well as consumer materials and address the relationship between nutrition and physical activity in a healthy lifestyle.

AoA will partner with the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Administration for Children and Families, and the Agency for Healthcare Research and Quality to implement the Steps to a Healthier US initiative. AoA will work with its partners in this initiative to develop activities targeting the needs of seniors.

CAREGIVER SUPPORT

Mr. Regula: Please tell us about the 5 basic components required in a State caregiver system.

Ms. Carbonell: The National Family Caregiver Support Program supports caregivers of the elderly, as well as grandparents and other relatives caring for grandchildren 18 years of age or younger. These caregivers are eligible to receive any of the five core services:

- Information about health conditions, resources and community-based long-term care services that might best meet a family's needs;
- Assistance in securing appropriate help;
- Counseling through support groups and caregiver training can help families make decisions and solve problems;
- Respite care, so that families and other informal caregivers can be temporarily relieved from their caregiving responsibilities. Respite can be provided in the caregiver's home, at an adult day services program, or at a long-term care facility; and
- Supplemental long-term care services on a limited basis. This could include home modifications; incontinence supplies; a microwave; air conditioner (for a caregiver with asthma or allergies); nutritional supplements; washing machine; assistive devices, etc. – essentially, whatever the caregiver needs.

Mr. Regula: Are people who receive services under the National Family Caregiver Support program encouraged to pay a fee for those services if they can or are they free of charge?

Ms. Carbonell: We have informed States that they have the option to allow cost sharing for services other than information and access assistance. The level of cost sharing is up to each State. A preliminary survey of States indicate that about 14 States have implemented cost sharing for some services and one other is considering doing so.

NUTRITION PROGRAMS

Mr. Regula: How many nutrition programs are there across the United States? Do you know what percentage of those programs receive federal funding either in part or in whole?

Ms. Carbonell: AoA does not collect information on nutrition programs that do not receive federal funding through the Older Americans Act (OAA). There are about 4,260 congregate nutrition service providers and about 3,900 home-delivered nutrition service providers that receive OAA funding. None of these service providers rely solely on federal funding to provide services. About 44 percent of the cost of a congregate meal and about 29 percent of the cost of a home-delivered meal comes from OAA funds.

In some communities, the same nutrition service organization provides both congregate and home-delivered services and in other communities, there are separate organizations. The structure of community-based nutrition service provision and the organizations used to provide these services is a local decision.

Mr. Regula: I understand that the home-delivered and the congregate meals programs have long waiting lists. What, if anything, is being done to move people wanting to take part in this important program off the waiting lists?

Ms. Carbonell: Older Americans Act (OAA) Nutrition Programs are funded by Federal, State, local and private resources and are administered by States and localities who use a variety of methods to meet the unique needs of local communities. Many States choose to maintain waiting lists for people looking to receive services. These lists are a tool to insure that those most in need are the first to receive services. We rely on State and local experience within the aging network to insure that available dollars serve as many seniors as possible by pulling together funds from multiple sources.

Over the years, States and local communities have tried to meet these needs through the provision of additional public (state general funds, county and city funds) and private funds (such as individual contributions, family contributions, corporate fund-raising). Although successful – about 56 percent of the cost of a congregate meal comes from non-OAA sources and about 71 percent of the cost of a home-delivered meal comes from non-OAA sources – waiting lists remain. With tight budgets at States and in local communities, as well as economic constraints on individuals and business, these additional sources of support may be limited. In addition, communities access intergenerational programs, corporate volunteers, food donations as well as a wide-range of other community resources to meet unique local needs.

Mr. Regula: Do you know how many elderly individuals are currently on waiting lists around the country?

Ms. Carbonell: AoA does not collect this information on a regular basis. Information from the 1996 national evaluation of the OAA Nutrition Programs, *Serving Elders at Risk*, indicated that 41 percent of home-delivered nutrition programs and 9 percent of congregate nutrition program had waiting lists for services, compared to 22 percent of other home and community-based services programs. The average

number of older adults on a home-delivered waiting list was 85 and had a wait of 2.6 months and the average number of older adults on a congregate waiting list was 52 and had a wait of 2.1 months.

Mr. Regula: Will the funding requested in this budget serve the same number of people or will it allow for a greater number of clients?

Ms. Carbonell: Our budget request for FY 2004 proposes to maintain funding for Nutrition Programs at levels that are approximately equal to the FY 2003 enacted level. We hope to be able to maintain the number of people served under this request. This will depend in part on the cost of providing these services, which is rising, particularly the cost of fuel which is a critical factor affecting the Home-Delivered meals program. OAA funds provide for about 44 percent of the cost of a congregate meal and about 29 percent of the cost of a home-delivered meal, so final service levels will depend in large part on the ability of States to continue to successfully leverage funds for these services.

Mr. Regula: Last year the Nutrition Services Incentive program was transferred from the Department of Agriculture to AoA. Please tell us more about that program. Why would a State choose to receive commodities rather than cash for this program?

Ms. Carbonell: According to Section 311 of the Older Americans Act (OAA), the purpose of the Nutrition Services Incentive Program (NSIP) is to provide incentives to encourage and reward effective performance by States and tribal organizations in the efficient delivery of nutritious meals to older individuals. NSIP provides financial support in the form of cash or commodities to support meal provision by community-based programs that meet the service requirements of the OAA.

Funds are allocated to a State or Tribe based on the number of meals served by a State or Tribe in proportion to the total number of meals served in the prior federal fiscal year. The State distributes these funds to local community-based nutrition service providers. NSIP funds may only be used to support meals and may not be transferred to other services, used for administrative costs, or be distributed by the interstate or intrastate funding formula. In collaboration with the Food and Nutrition Services (FNS) of the United States Department of Agriculture (USDA), commodities remain available to States and Tribes. The AoA is working collaboratively with FNS to minimize disruption to States and Tribes during this transitional year.

Under NSIP, States or Tribes may chose to receive commodities rather than cash if they perceive that they get a better value with commodities. The commodities are often as good a quality as commercial labels and yet may be cheaper. In addition, States and Tribes are able to access bonus commodities which may be available and are not charged to their grant allotment.

AGING "ONE-STOP SHOP" CENTERS

Mr. Regula: Where do you anticipate locating the new One-Stop Shop centers? What services will seniors be able to access or get information for through this new service delivery approach?

Ms. Carbonell: The "one-stop shop" resource centers will be located at the community-level to ensure that older adults, family caregivers and health and long-term care professionals experience easy access to the information and assistance they will provide. These "one-stop shops" can be housed in a physical location – such as a senior center, social services agency, health care center, community-center, – or they can be "virtual." The virtual "one-stop shops" will be available through a website or toll-free number that will guide the individual through the process to access needed services. Other variations of a resource center include the development of uniform information, assessment and eligibility processes shared by multiple service agencies so that there would be "no wrong door" through which to access needed services. In other words, one size does not fit all in this area. The Administration on Aging is focused on promoting streamlined access to health and long-term care services, not on dictating how this should occur. We will build on the strength of our network to respond to the unique local needs of the senior population to implement this program.

ELDERCARE LOCATOR

Mr. Regula: How many calls per year are there to the eldercare locator? Do you also have a website where one could find this information? If so, how many hits per year does it receive? How is the service advertised?

Ms. Carbonell: The Eldercare Locator can be accessed through its toll-free telephone line (800-677-1116) or website (www.eldercare.gov). In FY 2002, 124,830 callers received services through the toll-free number. There have been 383,572 users on the website since its inception in October 2001. We do not count "hits" because they are not a reflection of actual users of the service. A "hit" indicates a person has only viewed the page.

Brochures and promotional materials on the Eldercare Locator are distributed at conferences, mailed to State and local organizations, national associations and faith-based organizations. Staff exhibit the Eldercare Locator booth and distribute brochures and materials at national and regional conferences. AoA also conducts national outreach media campaigns, including "Home for the Holidays" and "Mother's Day" that advertise the Eldercare Locator service and include checklists for long distance family members.

This summer the expanded new interactive website, www.eldercare.gov will be available to search for local services from anywhere in the country. The new site includes fact sheets that can be downloaded to educate consumers on programs and services.

PENSION COUNSELING

Mr. Regula: Do you work with the Department of Labor, and in particular with the newly renamed Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration), in providing pension counseling services?

Ms. Carbonell: Yes. AoA works with the Department of Labor's Employee Benefits Security Administration (EBSA) in providing pension counseling services. The AoA Pension Counseling Program, which started in 1993, was the catalyst for the pension assistance that EBSA started providing through its field offices in 1997. The Labor Department has credited the AoA program with demonstrating that pension assistance could be provided efficiently and inexpensively. The AoA and EBSA programs now complement each others' activities.

Over the years the AoA Program has worked with EBSA's Office of Participant Assistance and Communications to develop an informal protocol for referring cases between EBSA field offices and the Pension Counseling projects. The AoA projects routinely refer cases involving mismanagement of private retirement plan assets and non-disclosure of plan documents, areas of particular interest to the Labor Department, to the EBSA field offices. EBSA refers clients with governmental plan problems, non-Employee Retirement Income Security Act (ERISA) and pre-ERISA claims, and private plan participants requiring detailed attention, to the AoA projects.

EBSA's staff regularly participate in Counseling Program training seminars, and have been very supportive of the AoA program. At the urging of AoA, EBSA recently established a toll free hotline for private retirement and health insurance questions. AoA will be collaborating closely with EBSA as it develops its one-stop pension assistance hotline and electronic infrastructure aimed at assuring that every older American with any kind of retirement question or problem will receive the information and assistance they are seeking.

Mr. Regula: I was surprised to read in the justification that in over 10 years, only 13,000 individuals have been served by this program, I would have assumed a higher number. How do seniors become aware of this program and what are you doing to advertise this service?

Ms. Carbonell: AoA's Pension Counseling and Information program has successfully obtained more than \$40 million in retirement benefits for approximately 13,000 individuals, a return of nearly \$5 for every federal dollar invested in the program. In the majority of these cases, whether due to the small dollar amount of the claim, or because the issues did not give rise to a class action, help would not have been available but for the Pension Counseling program. The program has also directly served another 20,000 clients by providing hands-on assistance in pursuing claims through their plans' administrative appeals processes, helping them locate pension plans "lost" as a result of mergers, acquisitions and terminations, providing plain-English answers to queries about

complex plan provisions, and making carefully targeted referrals to lawyers, actuaries and other professionals willing to help them obtain their much-needed pensions. Even when Pension Counseling projects are unable to secure benefits for clients, the information and assistance they provide frequently offers these vulnerable elderly individuals the satisfaction of finally achieving “peace of mind” after months or years of searching for answers.

Tens of thousands of other individuals have been indirectly served by the Counseling Program. Each Project produces helpful fact sheets and other publications, hosts a website, and provides important retirement income information to older Americans as part of its ongoing education and outreach efforts.

Individuals learn about the Pension Counseling program from a variety of national and local outreach efforts. The projects receive case referrals from State and federal government agencies, retiree, women’s, employee and other private organizations, consumer hotlines, State Bar Associations, and congressional offices. But by far the most effective outreach is through the media. The Pension Counseling program has received national coverage in the Readers Digest, the AARP Bulletin, Modern Maturity, USA Today, the New York Times, the Wall Street Journal, Kiplinger’s Personal Finance Magazine, Money, and numerous on-line publications such as businessweek.com. Project directors and staff also conduct seminars and workshops for retiree organizations, community groups, and senior centers, and appear on local radio and television programs to tell prospective clients about the services they provide. Several projects have advertised in community newspapers and disseminated public service announcements, and one project has advertised the services on the back of public buses. Word of mouth has also been an extremely effective form of reaching prospective clients.

WHITE HOUSE CONFERENCE ON AGING

Mr. Regula: Will there be additional requests for the White House Conference on Aging in subsequent years?

Ms. Carbonell: The FY 2004 budget request of \$2.842 million is a request for start-up costs only. We expect that there will be additional requests in subsequent years.

Mr. Regula: I understand that the White House Conference on Aging is a collaborative effort across government. Are other government agencies also contributing to the costs of this conference?

Ms. Carbonell: Historically, White House Conferences on Aging have been run by staff independent of AoA and have involved contributions from a variety of agencies across the government. While final decisions on the timing and scope of the conference have not been made yet, we anticipate that other HHS Operating Divisions and other Departments will also detail staff or provide in-kind assistance or other resources.

PRESCRIPTION DRUGS

Mrs. Northup: As the Administration works to allow seniors to have access to more affordable prescription drugs, how is it going to address the problem of medication related problems and errors?

Ms. Carbonell: Medication management among older adults is a growing issue due to the increasing availability of improved and stronger medicines and because of the physiological changes that occur with aging. To address this issue, AoA is part of the Assistant Secretary for Health's initiative on assuring the appropriate use of therapeutic agents (medicines) in the elderly. The major activity under this effort will be the development of an alert to the nation to address the appropriate use of medicines by the elderly. It is hoped that this activity will be completed by the end of the calendar year 2003.

As part of our Preventive Health Services program, AoA supports medication management, screening, and education to prevent incorrect medication and adverse drug reactions. These services help older adults learn more about important medication issues, including preventing interactions between drugs, following usage instructions, keeping track of medication regimens and getting professional advice. One activity at senior centers is the brown bag medicine programs where seniors come into the center, bring all their medicines including over the counter medicines and have a pharmacist review the contents of their bag. This is a very popular program with the seniors.

Mrs. Northup: Do you support a role for pharmacists in the Administration's disease/chronic care management initiatives?

Ms. Carbonell: Yes, there is a role for pharmacists in the Administration's disease/chronic care management initiatives. The Administration is testing a variety of approaches to disease management/coordinated care for Medicare beneficiaries, and many of these demonstration programs include some type of pharmacy benefit and/or management of medications, including beneficiary counseling and monitoring of pharmacy utilization. The counsel of a pharmacist on how and when medication should be taken can be an indispensable link in the chain of disease management treatment regimens. All Medicare payments for coordinated care services are made directly to the participating organizations, but those organizations, in turn, pay the various health care providers, including pharmacy benefit managers and pharmacists, who deliver the services.

Mrs. Northup: Residents of long-term care facilities are more ill and require more specialized, intensive medication therapy and clinical interventions than an outpatient senior. Most prescription drug benefit proposals are designed for an outpatient population that can receive medications through the mail or from a community pharmacy. How does the Administration intend to consider the issue of long-term care patients under a Medicare prescription drug benefit?

Ms. Carbonell: Medicare beneficiaries who are in a nursing home stay that is covered by Medicare already have the cost of their drugs paid for as part of the Medicare prospective payment system for nursing homes, similar to the way that prescription medications provided to inpatient hospital patients are paid.

Under a Medicare drug benefit, beneficiaries who would reside in a nursing home and are not in a covered Medicare stay would be eligible to have their prescription drug costs covered under the new Medicare prescription drug benefit in the same way that beneficiaries who reside in a nursing home and are not in a Medicare covered stay have Part B services paid for through Medicare Part B.

Mrs. Northup: Does the Administration anticipate making further changes to the Medicare Part B AWP issue?

Ms. Carbonell: The Administration has consistently indicated that we would prefer to work with Congress to develop a legislative solution and are hopeful this will occur. However, if the prospects for legislation are not promising, the Centers for Medicare and Medicaid Services is prepared to act administratively to reform the AWP methodology.

CAREGIVER SUPPORT

Mrs. Lowey: Women spend an average of 11.5 years out of the workforce, often to care for an ailing loved one or to raise a family. As written in your budget justification, "Families, not social service agencies, nursing homes, or government programs, are the mainstay of long-term care for older persons in the United States." That was made clear by a study in the journal *Health Affairs*, which stated that the contribution of America's caregivers to the nation is almost \$257 billion annually. Couple these costs with the fact that because monthly Social Security benefits are based upon the number of years that an individual or family wage-earner has spent in the workforce, these caregivers often lose out on needed retirement benefits. That is why I have introduced legislation that would ensure that those who dramatically scale back their work hours to provide care for a loved one will continue to accumulate Social Security savings.

Until legislation like mine passes, however, families will be ever more dependent on programs like National Family Caregiver Support (NFCSP). As you know, NFCSP provides needed information, counseling, respite, and supplemental services to caregivers. Yet, at the same time the senior population and life expectancy rates are growing, the Administration has proposed cutting this program by \$7.5 million. Can you please respond to the concerns that we are not doing enough to support our nation's caregivers?

Ms. Carbonell: Under Secretary Thompson's leadership, we have worked hard to implement the NFCSP, and increasing the number of families who are supported in their efforts to care for their loved ones at home and in the community is a top priority at AoA. Since the enactment of the NFCSP in November of 2000, AoA and its Aging Services Network has invested over \$400 million in Federal funds to provide information to families that will help sustain them in their caregiving roles; educate the public on the importance of supporting family caregivers; improve access to services; reach out to special populations and caregivers who may not be connected to service delivery networks; and permit employees to continue to contribute to the workforce. The Administration on Aging is also building new partnerships among informal caregivers, business and industry, and government to advance family caregiver support systems.

NFCSP formula grants are a key element in the federal government's efforts to assist States in supporting caregivers. These grants fund initiatives to develop and enhance comprehensive statewide systems of informal support. The importance of these federal grants cannot be understated since many States' implementation efforts are limited to only those activities funded by these grants.

The preliminary and partial data we have gathered begin to tell a story about the implementation of the program, and reflect State efforts to get the word out while developing well-rounded programs. These data indicates that the States reached out to

over 1.3 million caregivers with information about caregiver programs and services. Access assistance services were provided to approximately 325,000 caregivers, which significantly exceeds the agency targets to serve 250,000 caregivers. Significant numbers of caregivers have also been reached with intensive, direct services reflected by respite, counseling and training and supplemental services. The preliminary partial data indicate that states served almost 150,000 caregivers with counseling and training services; provided respite to over 60,000 caregivers; and provided supplemental services to over 45,000 caregivers.

In addition, in FY 2002, the Administration on Aging sponsored 39 competitive research and demonstration projects under the National Family Caregiver Support Program. These competitive grants focus on systems development; service components; linkages to special populations and communities; field-initiated demonstrations to develop and test new approaches to support caregivers; and national projects that enhance the development of caregiver programs.

In New York, for example, two competitive research and demonstration projects have been awarded. The Catholic Family Center of Rochester, New York is collaborating with 15 national and local organizations to create an integrated approach to support relative caregivers of grandchildren through a wide range of services, case coordination and management, legal consultations, support groups, educational workshops, and access to counseling and emergency services from a single entry point. The Senior Service Centers of the Albany, New York area is demonstrating the effectiveness of support groups for caregivers of frail elders via telephone conferencing technology. This multi-component group program includes emotion-focused and problem-focused coping strategies and support.

The President's FY 2004 budget proposed to maintain funding for the caregiver program at the same level as both the FY 2003 request and the FY 2002 appropriation. This request was submitted prior to the enactment of final appropriations for FY 2003 and any reduction in funding for FY 2004 is a result of unanticipated increases in the final FY 2003 appropriation.

HEALTH PROMOTION

Mrs. Lowey: I could not agree with you and the President more about the need to increase efforts to promote physical activity, walking programs, improved diet, and healthy lifestyle choices amongst seniors. As the Democratic sponsor of the Improved Nutrition and Physical Activity Act (IMPACT), which I introduced with Reps. Bono and Granger, I realize the need to make communities more conducive to activity and exercise - especially for our seniors. While I was pleased to read about the Steps to a Healthier US initiative in your testimony and glad to learn that it will involve your department, I am concerned that the Administration is merely reinventing the wheel. At the same time the Administration is touting this \$125 million effort as the key to promoting healthier living, it is cutting funding for CDC's Nutrition and Physical

Activity, Chronic Disease Prevention, and Health Promotion programs - programs that have already taken up this cause. In your testimony, you discuss ongoing collaborations with the CDC. Will the CDC program cuts impact your current efforts? The reduction of CDC funding is almost \$30 million. While that still provides for \$95 million in new dollars under Steps, will there be room for improvement and further gains to our efforts to promote healthier lifestyles for seniors?

Ms. Carbonell: While it would not be appropriate for me to discuss the President's budget request for CDC, I expect that AoA and CDC will continue to build partnerships to carry out activities geared toward seniors which focus on health promotion, disease prevention, and healthy lifestyles. We look forward to working with CDC and other agencies in the Department to implement the Steps to a Healthier US initiative, which will use proven medical and public health interventions to reduce the burden of chronic diseases such as diabetes, asthma, and obesity.

This new effort will build on existing partnerships between CDC and AoA such as the Aging States Project, which seeks to enhance communication and coordination between State Units on Aging and State Health Departments. As part of this partnership, AoA and CDC pooled resources to support health promotion projects targeting seniors which promote physical activity, walking programs, improved diet, and healthy lifestyle choices.

1904



**DEPARTMENT
of HEALTH
and HUMAN
SERVICES**

Fiscal Year

2004

**Administration
on Aging**

*Justification of
Estimates for
Appropriations Committees*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

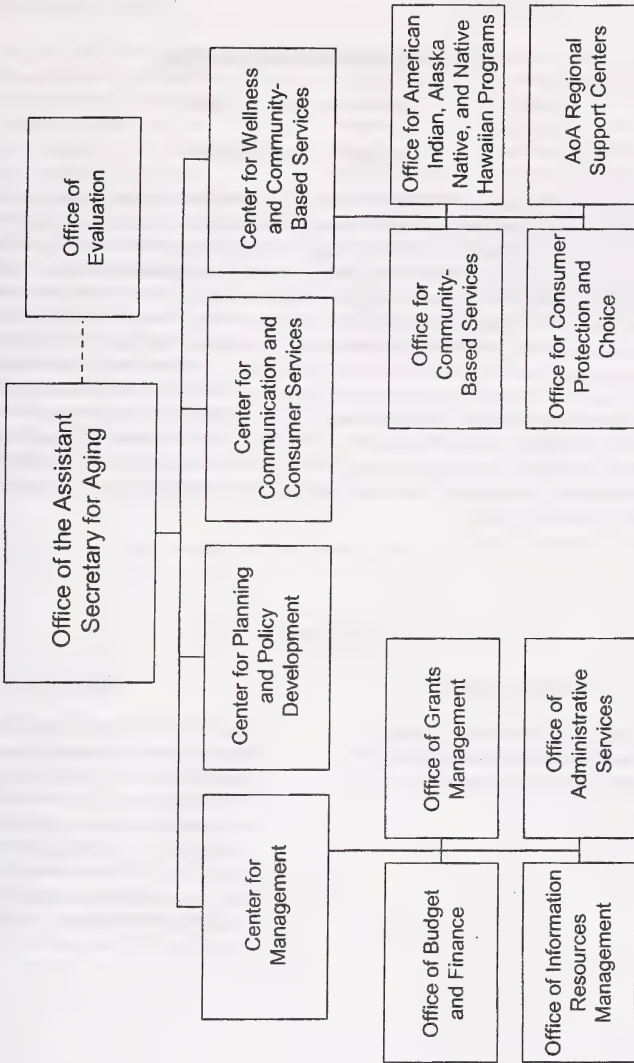
ADMINISTRATION ON AGING

AGING SERVICES PROGRAMS

<u>FY 2004 Budget</u>	<u>Page No.</u>
Organization Chart.....	1
Appropriations Language and Explanation of Changes.....	2
Amounts Available for Obligation.....	4
Summary of Changes	5
Budget Authority by Activity	6
Budget Authority by Object Class	7
Salaries and Expenses	8
Significant Items in House and Senate Appropriations Committee Reports	9
Program Assessment Rating Tool	11
Authorizing Legislation.....	12
Appropriations History Table.....	14
Justification:	
General Statement	15
Home and Community-Based Supportive Services.....	21
National Family Caregiver Support Program.....	24
Congregate Nutrition Services.....	27
Home-Delivered Nutrition Services.....	30
Nutrition Services Incentive Program	33
Preventive Health Services	35

Program Innovations	38
Aging Network Support Activities	43
Grants For Native Americans	45
Protection Of Vulnerable Older Americans	48
Alzheimer's Disease Demonstration Grants	51
Program Administration	54
White House Conference on Aging	58
State Tables.....	59
Research Coordination Council Activities	73
Detail of FTE Employment.....	75
Detail of Positions	76
New Positions Requested.....	77

ADMINISTRATION ON AGING ORGANIZATIONAL CHART



Appropriations Language

Administration on Aging

Aging Services Programs

For carrying out, to the extent not otherwise provided, the Older Americans Act of 1965, as amended, and section 398 of the Public Health Service Act, [\$1,342,357,000] \$1,343,701,000 of which \$5,000,000 shall be available for activities regarding medication management, screening, and education to prevent incorrect medication and adverse drug reactions; *of which \$2,842,000 shall remain available until September 30, 2006 for the White House Conference on Aging*; and of which \$149,670,000 shall be [allocated to States] *for making payments to or on behalf of States and other eligible grantees, consistent with [the formula in] section 311 of the Older Americans Act of 1965: Provided, That references to the Secretary of Agriculture in section 311(b) and (d)(1) shall be deemed to be references to the Secretary of Health and Human Services: Provided further, That in those instances in which the eligible entity elects to receive its allotment, in part or in total, in the form of commodities, the Secretary of Agriculture shall supply such commodities and be reimbursed for the costs thereof from amounts provided herein.*

Exhibit D-2

Language Analysis

<u>Language Provision</u>	<u>Explanation</u>
"of which \$2,842,000 shall remain available until September 30, 2006 for the White House Conference on Aging."	Section 211 of the Older Americans Act requires a White House Conference on Aging to be convened by no later than December 31, 2005 and authorizes such sums as may be necessary. The language designates the \$2,842,000 requested for start-up and initial planning costs for a White House Conference on Aging as available for three-years.

Language Provision

of which \$149,670,000 shall be for making payments to or on behalf of States and other eligible grantees, consistent with section 311 of the Older Americans Act of 1965: Provided, That references to the Secretary of Agriculture in section 311(b) and (d)(1) shall be deemed to be references to the Secretary of Health and Human Services: Provided further, That in those instances in which the eligible entity elects to receive its allotment, in part or in total, in the form of commodities, the Secretary of Agriculture shall supply such commodities and be reimbursed for the costs thereof from amounts provided herein.

Explanation

Transfers the Department of Agriculture (USDA) Nutrition Services Incentive Program to the Administration on Aging. Insures that funds continue to be dedicated exclusively to the provision of meals, preserves the option for States to receive commodities from USDA in lieu of cash, and provides for costs related to the provision of commodities to be reimbursed to USDA from amounts available under the appropriation.

Amounts Available For Obligation
(Dollars in Thousands)

	2002 <u>Actual</u>	2003 President's <u>Budget</u>	2004 <u>Estimate</u>
Appropriation:			
Annual.....	1,199,814	1,341,344	1,343,701
Enacted Rescission:			
Public Law 107-116.....	(37)	--	--
Public Law 107-206 Section 803.....	(89)	--	--
Public Law 107-206 Section 1403.....	(17)	--	--
Subtotal, Adjusted Appropriation.....	1,199,671	1,341,344	1,343,701
Comparable Transfer From:			
USDA Nutrition Services Incentive Program.....	149,670	--	--
Offsetting Collections From:			
Centers for Disease Control and Prevention.....	14	--	--
Office on Women's Health.....	125	--	--
Unobligated Balance: Start of Year.....	1,643	909	176
Unobligated Balance: End of Year.....	909	176	-
Unobligated Balance Lapsing.....	(137)	--	--
Total Obligations.....	1,350,077	1,342,077	1,343,877

Summary of Changes
(Dollars in Thousands)

2003 President's Budget.....	1,341,344
2004 Estimate.....	1,343,701
Net change.....	2,357

	<u>Budget Authority</u>	<u>Budget Authority</u>
Increases:		
<u>A. Built-in:</u>		
1. Provide for January 2004 2.0% pay raise and related pay costs.....	11,144	420
2. Increased costs related to GSA rent.....	1,738	32
Subtotal, Built-In Increases.....		452
<u>B. Program</u>		
1. White House Conference on Aging.....	--	2,842
2. Increased costs related to travel, communications, printing, supplies, and equipment.....	1,142	17
Subtotal, Program Increases.....		2,859
Total, Increases.....		3,311
Decreases:		
<u>A. Built-in:</u>		
1. Decreased costs related to administrative savings.....	10,337	(349)
2. Decreased costs related to information technology consolidation...	10,337	(383)
Subtotal, Built-In Decreases.....		(732)
<u>B. Program:</u>		
1. Decrease costs related to GSA rent.....	1,738	(73)
2. Decrease costs related to program contracts.....	10,337	(149)
Subtotal, Program Decreases.....		(222)
Total, Decreases.....		(954)
Total, Net Change.....		2,357

Budget Authority by Activity
(Dollars in Thousands)

Program	FY 2002 Actual		FY 2003 President's Budget		FY 2004 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
Home & Community-Based Supportive Services..	--	\$356,981	--	\$357,000	--	\$357,000
National Family Caregiver Support Program.....	--	141,492	--	141,500	--	141,500
Congregate Nutrition Services.....	--	390,000	--	390,000	--	390,000
Home-Delivered Nutrition Services.....	--	176,500	--	178,500	--	178,500
Nutrition Services Incentive Program /1.....	--	149,670	--	149,670	--	149,670
Preventive Health Services.....	--	21,123	--	21,562	--	21,562
Program Innovations.....	--	38,257	--	27,837	--	27,837
Aging Network Support Activities.....	--	2,379	--	2,379	--	2,379
Grants for Native Americans.....	--	25,722	--	25,729	--	25,729
Protection of Vulnerable Older Americans.....	--	17,681	--	17,681	--	17,681
Alzheimer's Disease Demonstration Grants.....	--	11,483	--	11,500	--	11,500
Program Administration /2.....	112	18,053	112	17,986	112	17,501
White House Conference on Aging.....	--	--	--	--	--	2,842
Total, Discretionary Budget Authority.....	112	\$1,349,341	112	\$1,341,344	112	\$1,343,701
Senior Medicare Patrols (HCFAC) /2.....	8	\$2,000	8	\$3,000	8	\$3,000
Total, Program Level.....	120	\$1,351,341	120	\$1,344,344	120	\$1,346,701

1/ Reflects proposed transfer from the Department of Agriculture. FY 2002 and FY 2003 are displayed on a comparable basis

2/ FTE distribution has been adjusted from the February 2003 President's Budget, which was prepared before FY 2002 HCFAC levels were finalized. Total FTE levels are unchanged. FY 2003 and FY 2004 HCFAC amounts are placeholders; the Secretary and the Attorney General will negotiate final amounts.

BUDGET AUTHORITY BY OBJECT
(Dollars in Thousands)

	2003 President's <u>Budget</u>	2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Full-time equivalent employment.....	120	120	--
Full-time equivalent of overtime and holiday hours....	--	--	--
Average SES Salary.....	134	136	2
Average GS Grade.....	13/4	13/4	--
Average GS Salary.....	73	76	3
Personnel Compensation:			
Full-time Permanent.....	8,958	9,294	336
Other than Full-Time Permanent.....	93	97	4
Other Personnel Compensation.....	219	223	4
Subtotal, Personnel Compensation.....	9,270	9,614	344
Personnel Benefits.....	1,874	1,950	76
Subtotal, Pay Costs.....	11,144	11,564	420
Travel and Transportation of Persons.....	457	464	7
Transportation of Things.....	10	10	--
Rental Payments to GSA.....	1,738	1,697	(41)
Communications, Utilities, and Miscellaneous.....	243	246	3
Printing and Reproduction.....	194	197	3
Other Contractual Services:			
Advisory and Assistance Services.....	6,019	5,845	(174)
Other Services.....	579	535	(44)
Purchases from Government Accounts.....	3,731	5,912	2,181
Operation and Maintenance of Equipment.....	8	6	(2)
Subtotal, Other Contractual Services.....	10,337	12,298	1,961
Supplies and Materials.....	116	118	2
Equipment.....	122	124	2
Grants, Subsidies and Contributions /1.....	1,316,983	1,316,983	--
Subtotal, Non-Pay Costs	1,330,200	1,332,137	1,937
Total, Budget Authority by Object Class.....	1,341,344	1,343,701	2,357

1/ Funding for the Nutrition Services Incentive Program is included for both years.

Salaries and Expenses
(Dollars in Thousands)

	2003 President's <u>Budget</u>	2004 <u>Estimate</u>	Increase or <u>Decrease</u>
Personnel Compensation:			
Full-time Permanent (11.1).....	8,958	9,294	336
Other than Full-Time Permanent (11.3).....	93	97	4
Other Personnel Compensation (11.5).....	219	223	4
Subtotal, Personnel Compensation	9,270	9,614	344
Personnel Benefits (12.1).....	1,874	1,950	76
Subtotal, Pay Costs	11,144	11,564	420
Travel and Transportation of Persons (21.0).....	457	464	7
Transportation of Things (22.0).....	10	10	--
Communications, Utilities, and Miscellaneous (23.3).....	243	246	3
Printing and Reproduction (24.0).....	194	197	3
Other Contractual Services:			
Advisory and Assistance Services (25.1).....	6,019	5,845	(174)
Other Services (25.2).....	579	535	(44)
Purchases from Government Accounts (25.3).....	3,731	5,912	2,181
Operation and Maintenance of Equipment (25.7).....	8	6	(2)
Subtotal, Other Contractual Services	10,337	12,298	1,961
Supplies and Materials (26.0).....	116	118	2
Subtotal, Non-Pay Costs	11,357	13,333	1,976
Total, Salaries and Expenses	22,501	24,897	2,396

SIGNIFICANT ITEMS IN COMMITTEE REPORTS

The following section represents FY 2003 Congressional requirements for reports and significant items derived from Senate Report 107-216. These actions discussed below are contingent on inclusion of similar language and funding in the final FY 2003 appropriation and related reports. Additional items may be transmitted at a later date as a result of the final Conference report.

Language Included in Senate Report 107-216

Item

Nutrition Services Incentive Program – The Committee agrees with the administration's request to shift funding for the Nutrition Services Incentive Program (NSIP) from the Food and Nutrition Service within USDA to the Administration on Aging within the Department of Health and Human Services (DHHS). It is the Committee's belief, however, that it is critically important for several aspects of NSIP to remain intact, as the program is shifted into DHHS. This includes the allocation of NSIP funds on the basis of the number of meals served in a State in the previous year, as opposed to the number of seniors that reside in that State. Further, NSIP funds are not currently, and should not become, subject to transfer, expenditure for administrative costs, or match requirements, and States should continue to have the option of receiving benefits in the form of cash or commodities. The Committee directs the Under Secretary of the Food and Nutrition Service to work with the Assistant Secretary for Aging within DHHS to ensure this transfer of funding and responsibilities is carried out in a manner that in no way disrupts the delivery of services provided by NSIP. The Committee has maintained access to commodities within USDA because the agency has both the infrastructure and the expertise to conduct this activity that is not available in AoA and HHS.

Action Taken or To Be Taken

The FY 2004 budget modifies the proposal in the FY 2003 budget by transferring the Nutrition Services Incentive Program (NSIP) intact from the Department of Agriculture (USDA) to AoA. Under the proposed language for FY 2004, NSIP funds would continue to be allocated on the basis of the number of meals served in a State in the previous year, and funds would continue to be available exclusively for the provision of meals and would not be subject to transfer, expenditure for administrative costs, or match requirements. Further, the language maintains the option for States to receive benefits in the form of cash or commodities. Under the proposal, AoA would work with USDA to provide commodities and to ensure this transfer of funding and responsibilities is carried out in a manner that in no way disrupts the delivery of services provided by NSIP.

Item

Retired nurses, doctors, accountants and other professionals – The Committee has provided support at last year's level to continue the pilot project to test the best ways of using the skills of retired nurses, doctors, accountants, and other professionals to train other seniors and to serve as expert resources to detect and stop Medicare fraud, waste and abuse. The Committee expects that these funds will be used to make grants and that administrative costs will be minimized. In addition, the Committee expects that an improved system will be developed and implemented in coordination with CMS and the OIG to track cases referred by this initiative.

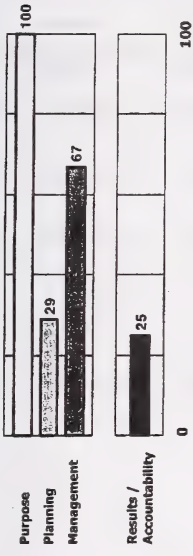
Action Taken or To Be Taken

During the past fiscal year, the Administration on Aging (AoA) funded 52 Senior Medicare Patrol Projects for the purpose of recruiting retired nurses, doctors, accountants, and other professionals to train other seniors and to serve as expert resources to detect and stop Medicare and Medicaid fraud, waste, and abuse. Over the past twelve months, nearly 9,000 new volunteers were trained and more than 400,000 beneficiaries were directly educated by the retired volunteers. An additional 5 million individuals were estimated to be reached through a variety of television, radio, and print media events. Particular attention was focused on reaching individuals with low health literacy and limited English proficiency, as well as persons living in rural areas.

AoA also launched a website and convened a national conference designed to promote consumer awareness and facilitate the sharing of information and best practices between Medicare and Medicaid beneficiaries, the Senior Medicare Patrol projects, and Federal, State and local partners. The website links seniors to information about how to become a volunteer.

In total, over the course of the demonstration, the projects have trained more than 31,000 volunteers who have directly educated nearly 900,000 seniors. As a result of these activities, nearly 20,000 complaints have been reported for further examination by the Centers for Medicare and Medicaid Services, the Office of Inspector General, or the Department of Justice. Approximately 1,800 of these complaints have resulted in some action being taken. In total, closed complaints that have been tracked to date have resulted in the recoupment of \$3,008,937 in Medicare funds and \$76,621,601 for the Medicaid program and others.

Program: State and Community-Based Services
Agency: Department of Health and Human Services
Bureau: Administration on Aging



☐ Results Achieved
☒ Results Not Demonstrated
☐ Measures Adequate
☒ New Measures Needed

Key Performance Measures		Year	Target	Actual
Long-term Measure: Rate of non-AoA funds leveraged to each \$1.00 of program funding (Targets under development)		2000	\$1.50	\$1.90
		2001		
		2002		
		2003		
Annual Measure: Measure under development				
Efficiency Measure: Measure under development				

Rating: Results Not Demonstrated
Program Type: Block/Formula Grants
Program Summary:

The Administration on Aging (AoA) attempts to enable elderly people to remain in their homes and communities. These programs and services include such activities as meals in community settings and home-delivered, preventive health care, senior centers and support of family caregivers.

The assessment indicates that the overall program has a clear purpose, addresses a specific need, and is effectively designed. However, performance measurement should be strengthened. Findings include:

1. There is a lack of focus on program outcomes in performance measures. The proposed annual targets maintain current performance rather than support long-term improvements. For example, while AoA encourages states to leverage funds from non-federal sources, the 2004 target is \$1.90 to \$1.00, the same level that has been achieved since 1998.
2. While AoA monitors the financial performance of grantees, it does not actively promote efficiencies, utilize full cost accounting or proactively identify management deficiencies.
3. State and local entities have a great deal of flexibility in designing the programs and leveraging funds. Therefore, grantees cannot be required to adopt AoA's goals and measures, and it is difficult to determine how changes in federal funding may affect program performance.
4. The most recent program evaluation indicated positive outcomes are achieved. However, AoA's annual performance plans do not track or measure these outcomes. Performance measures and targets should be revised to reflect and improve these outcomes.

In response to these findings, the Administration will work with AoA to reevaluate its performance measures to reflect program outcomes, and to develop appropriate performance targets.

Program Funding Level (in millions of dollars)

2002 Actual	2003 Estimate	2004 Estimate
1,200	1,341	1,344

AUTHORIZING LEGISLATION

	2003 Authorized <u>Amount</u>	2003 President's <u>Budget</u>	2004 Authorized <u>Amount</u>	2004 Budget <u>Request</u>
1) Home and Community- Based Supportive Services: OAA Section 321.....	Such Sums	\$357,000,000	Such Sums	\$357,000,000
2) Nutrition:				
A) Congregate Nutrition Services: OAA Section 331..	Such Sums	\$390,000,000	Such Sums	\$390,000,000
B) Home-Delivered Nutrition Services: OAA Section 336..	Such Sums	\$178,500,000	Such Sums	\$178,500,000
C) Nutrition Services Incentive Program: OAA Section 311..	Such Sums	\$149,670,000	Such Sums	\$149,670,000
3) Preventive Health Services: OAA Section 361.....	Such Sums	\$21,562,000	Such Sums	\$21,562,000
4) National Family Caregiver Support Program: OAA Section 371.....	Such Sums	\$141,500,000	Such Sums	\$141,500,000
A) Innovations: OAA Section 375.....	[\$5,440,000]	[\$5,440,000]	Expired	--
B) National Significance: OAA Section 376.....	[\$1,360,000]	[\$1,360,000]	Expired	--
C) Native Americans: OAA Section 631.....	Such Sums	[\$5,500,000]	Such Sums	[\$5,500,000]
5) Program Innovations: OAA Section 411.....	Such Sums	\$27,837,000	Such Sums	\$27,837,000
6) Aging Network Support Activities: OAA Section 201.....	Such Sums	\$2,379,000	Such Sums	\$2,379,000
A) Eldercare Locator: OAA Section 202.....	Such Sums	/1	Such Sums	/1
B) Pension Counseling: OAA Section 215.....	Such Sums	/1	Such Sums	/1
7) Grants to Indian Tribes: OAA Section 613 and 623.....	Such Sums	\$25,729,000	Such Sums	\$25,729,000

1919

	2003 Authorized Amount	2003 President's Budget	2004 Authorized Amount	2004 Budget Request
8) Protection of Vulnerable Older Americans: OAA Section 702..	Such Sums	\$17,681,000	Such Sums	\$17,681,000
A) Ombudsman: OAA				
Section 712.....	Such Sums	/1	Such Sums	/1
B) Elder Abuse: OAA				
Section 721.....	Such Sums	/1	Such Sums	/1
9) Alzheimer's Disease Demonstration Grants:				
PHSA Section 398.....	Expired	\$11,500,000	Expired	\$11,500,000
10) Program Administration:				
OAA Section 205.....	Such Sums	\$17,986,000	Such Sums	\$17,501,000
11) White House Conference on Aging: OAA Section 211.....	Such Sums	--	Such Sums	\$2,842,000
Total Request Level.....		\$1,341,344,000		\$1,343,701,000

Unfunded Authorizations:

1) Legal Assistance: OAA				
Section 731.....	Such Sums	--	Such Sums	--

1/ Does not specify amounts for activities within the overall program.

APPROPRIATIONS HISTORY TABLE
AGING SERVICES PROGRAMS

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
1995	875,485,000	869,823,000	873,662,000	876,236,000
1995 Rescission	--	--	--	-1,216,000
1996	897,148,000	778,246,000	836,027,000	829,320,000
1996 Rescission	--	--	--	-73,000
1997	828,137,000	810,545,000	830,168,000	830,168,000
1997 Rescission	--	--	--	-37,000
1998	838,168,000	815,545,000	894,074,000	865,050,000
1999	871,050,000	861,020,000	876,050,000	882,020,000
1999 Rescission	--	--	--	-9,000
1999 Transfer	--	--	--	-281,000
2000	1,048,055,000	881,976,000	928,055,000	934,285,000
2000 Rescission	--	--	--	-1,437,000
2000 Transfer /1	--	--	--	-184,000
2001	1,083,619,000	925,805,000	954,619,000	1,103,135,000
2001 Rescission	--	--	--	-42,000
2001 Transfer	--	--	--	-151,000
2002	1,097,718,000	1,144,832,000	1,209,756,000	1,199,814,000
2002 Rescission /2	--	--	--	-143,000
2003 /3	1,342,357,000	N/A	N/A	N/A
2004	1,343,701,000			

1/ Reflects two separate transfers of -\$121,000 and -\$63,000.

2/ Reflects three separate rescissions of -\$37,000, -\$17,000, and -\$89,000.

3/ Budget Estimate to Congress included \$1,013,000 for a legislative proposal related to accruing employee health and retirement benefits.

General Statement

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$1,349,341,000	\$1,341,344,000	\$1,343,701,000	+\$2,357,000
FTE	120	120	120	--

The Administration on Aging (AoA) is requesting a total funding level of \$1,343,701,000 and 120 FTE for FY 2004, an increase of +\$2,357,000 over the FY 2003 President's Budget. The request maintains current levels of funding for core home and community-based services programs, including nutrition and caregiver services. The request also provides first-year funding for a White House Conference on Aging and supports the continued implementation of the President's Management Agenda.

The request continues support for AoA's efforts to better coordinate existing service systems and maximize available resources through collaborations with other agencies on issues affecting seniors and their families. In FY 2004, AoA will build on these efforts by working with the Centers for Disease Control and Prevention and other agencies on a new Disease Prevention Initiative targeted on diabetes, asthma, and obesity. The request also provides continued support for resource centers and other projects that disseminate information about aging issues and help States and communities to integrate, target and deliver services in a more efficient and cost-effective manner.

AoA and the Aging Network

As the Federal advocacy agency for the elderly, AoA's mission is to help older people retain their dignity and independence and remain in their own homes and communities. AoA programs, funded under the Older Americans Act (OAA) and the Public Health Service Act, complement, for a fraction of the cost, existing medical and health care systems and support some of life's most basic functions: food for the undernourished; transportation for the immobile; respite and support for caregivers; and personal care to those who need assistance getting in and out of bed, feeding and bathing themselves. All Americans age 60 and over are eligible for services, with emphasis given to serving the disadvantaged elderly.

AoA programs are consumer-oriented, community-based, and strongly supported by volunteers. AoA works in partnership with a national aging service network that includes 56 State Units on Aging (SUA), 655 Area Agencies on Aging (AAA), 243 Indian Tribal Organizations, and over 29,000 public, private and voluntary direct service providers including over 10,000 senior centers (more than half of which are "community focal points" that coordinate and integrate services for the elderly). Approximately

500,000 volunteers (including over 40% of AAA staff) work with the network's service providers.

This provider network renders direct services to almost 7 million elderly individuals each year (15% of the 60 plus population), including approximately 3 million registered clients who receive intensive in-home services, and to approximately 250,000 caregivers. OAA programs successfully target services to the most vulnerable elderly. Over 60% of home-delivered meal recipients are disabled and need assistance with activities of daily living. Whereas 10% of the elderly population is poor, approximately 30% of our clients are poor. Whereas just under 25% of the elderly population lives in rural areas, just over 30% of our clients live in rural areas. Whereas 16% of the elderly population are minorities, 19% of our clients are minorities.

Because OAA home and community-based social supports focus on prevention, they help delay the need for more expensive medical supports and produce results at a fraction of the cost of long-term care institutions. These services help to:

- Prevent the institutionalization of vulnerable elderly people through the 11 million hours of personal care provided each year; and the support and respite services that are provided to over 250,000 caregivers;
- Prevent immobility by providing approximately 40 million rides each year. AoA outcome measure pilot surveys (not national samples) estimate that 20% of transportation clients rely on our services for all, or almost all, of their transportation needs. Most transportation is to get to the doctor and other medical appointments.
- Prevent depression, disease, and health deterioration through the over 250 million meals that we provide each year, which help participants to prevent or manage cardiovascular disease, diabetes and osteoporosis; and by providing physical activities, medication management, and the opportunity for conversation and social interaction through our senior centers, used by over 1.7 million people each year.
- Prevent debilitating injuries that constitute one of the greatest threats to frail elderly individuals through over 10 million units of homemaker services, 1.3 million units of chore services, and over 10 million units of adult day care; and,
- Prevent loss of independence, financial exploitation, and abuse and neglect through 1.2 million hours of legal assistance, through pension counseling, and through over 13 million information and referral contacts with the elderly and their caregivers.

The statistical average annual cost for services provided per elderly client is approximately \$600 (as reported by SUAs). AoA estimates that the cost of providing OAA services to a vulnerable individual receiving multiple services, such as homemaker, personal care, home-delivered meals, chore services, and assisted transportation, is \$3,000 annually. This is significantly less than the approximately \$40,880 annual cost of nursing home care.

The national aging network successfully leverages Federal funding (which on average constitutes only a third of the total funding expended) to build coordinated service systems at the State and local level. For every \$1 of Federal funding, States and local communities leverage an additional \$2 from other sources; for intensive in-home services, the ratio is \$3 to \$1. The OAA provides flexibility in the use of funds to address the needs of consumers at the local level. The mandated planning process starts at the local level, moves to the State level, and includes consumer input at all levels.

FY 2004 Budget Request

The FY 2004 request of \$1,343,701,000 maintains the levels of funding appropriated in FY 2002 and requested in FY 2003 for AoA's core nutrition, home and community-based supportive services, caregiver services, preventive health, and Native American programs. AoA will work closely with its stakeholders and aging network partners to maintain current levels of service in FY 2004. The request also provides continued funding at current levels for long-term care ombudsmen, pension counseling, the eldercare locator, prevention of elder abuse and neglect, and the development and testing of effective models for caring for those with Alzheimer's disease.

The FY 2004 budget continues to propose the transfer of funding for the Nutrition Services Incentive Program (NSIP) from the Department of Agriculture (USDA) to AoA. However, in response to feedback from our State and aging network partners, the FY 2004 proposal has been modified such that it transfers the program intact from USDA to AoA. Funds will continue to be distributed via the current USDA formula which is based on the number of meals served in the prior year. AoA will work with USDA to ensure that States that wish to receive commodities in lieu of cash may continue to do so.

The President's budget also continues support for Program Innovation projects that develop, initiate, and test promising practices that the aging network can use to more effectively support older persons and their families. One way AoA has maximized the value of these resources and sought to better coordinate existing services and systems is by building partnerships with other Federal agencies, both inside and outside of HHS, as well as with non-Federal entities. Some examples of these collaborations include:

- **Systems Change:** AoA is working with the Centers for Medicare and Medicaid Services (CMS), the Assistant Secretary for Planning and Evaluation, the Substance Abuse and Mental Health Services Administration, and other HHS agencies on efforts to help States redirect and integrate their systems of care to respond to older people's preference for care in the community. These efforts include collaborating on research projects to identify State trends in long term care and to develop case studies on flexible service models that have been used by States to create more community options for older people; ensuring that the aging services network is involved in the Real Choice Systems Change Grants initiative; evaluating projects that promote "Aging In Place"; and promoting the use of Medicaid waivers and Consumer Directed Care models.

- Aging States Project: AoA is working with the Centers for Disease Control and Prevention (CDC) to enhance communication and coordination between State Units on Aging and State Health Departments, and collaborating on a health promotion project targeting older adults. AoA and CDC pooled resources to support demonstration projects that promote physical activity, walking programs, and improved diet consistent with the President's Healthier US initiative; provide enhanced information on health promotion and physical activity to older individuals; and establish new statewide public health and aging network partnerships.
- USA on the Move: As part of the President's Healthier US Initiative, AoA is working in partnership with the National Policy and Resource Center on Nutrition and Aging to develop the USA on the Move: Steps to Healthy Aging initiative. This initiative is designed to improve nutrition and physical activity in older adults by working with State Units on Aging and local partners to disseminate information about simple and low cost ways to eat healthier and by promoting the use of step counters to inspire older adults to walk more.
- Quality of Care: AoA and CMS partnered to involve the Long-Term Care Ombudsmen program in CMS' Nursing Home Quality Indicator Initiative (QI). The goal of the QI initiative is to help consumers make informed nursing home placement and quality care decisions by providing them with objective indicators they can use to compare the quality of care in different nursing home facilities. The AoA/CMS partnership capitalizes on the vast experience of the over 8,000 certified volunteer ombudsmen who help consumers make decisions about nursing home placement and quality of care.
- Transportation: AoA and the Federal Transit Administration are partnering to increase coordination of transportation services for older adults. Transportation is a key to helping older people remain independent and in the community. The partnership involves collaboration in five areas: public awareness and outreach, data collection, technical assistance, stakeholder input, and promoting coordinated planning and funding at the State and local level. Activities will focus on disseminating information on "promising practices" in coordinated transportation services for the elderly, as well as conducting regional technical assistance sessions for State governments to promote models and approaches for coordinating transportation resources at the State level and local level.

AoA will build on these collaborations in FY 2004 by working with CDC and other agencies to support a new Department-wide Disease Prevention initiative targeted on diabetes, asthma, and obesity. Research reveals that these diseases are growing problems for older adults. For instance: 15%-23% of the adults over 60 are obese; diabetes is the sixth leading cause of death for persons aged 65 years or older; and 2 million people age 65 and older have asthma. AoA will work with CDC and others to support competitive education and health promotion grants in nutrition, diabetes, and asthma which target older individuals, including an emphasis on reaching out to ethnic

and minority elders with high incidences of chronic illnesses.

Program Innovations funding also provides ongoing support for a number of national resource centers that assist State and Area Agencies with information, technical assistance, and services focused on specific aging issues. In FY 2004, AoA will use existing resources to refocus current efforts to develop citizen-centered systems of long-term care and make better use of funds by promoting and supporting the establishment of Aging "One-Stop Shop" Centers. The goal of this effort will be to eliminate the confusion and frustration people now face by serving as a visible and trusted resource where people can obtain objective information about their long-term care options. It will also provide information on best-practices and assist States to replicate the significant strides that a handful of States, such as Colorado, Oregon, Texas, Vermont, Washington, and Wisconsin, have made in creating more citizen-centered systems of care by reducing nursing home expenditures and increasing community-based choices while containing costs.

The FY 2004 request also includes \$2,842,000 in three-year funding to cover start-up costs for a White House Conference on Aging. White House Conferences on Aging have served as catalysts for the development of aging policy for the past 40 years and have prompted the development of many of the programs that represent America's commitment to the elderly. The recommendations made by these conferences have resulted in improvements in the programs which assist seniors and their families and have led to better quality of life for older Americans.

Finally, the FY 2004 request reflects the President's commitment to improving program management. Built into the request of \$17,501,000 for Program Administration is an increase of \$247,000 to partially offset the cost of projected pay increases. The request maintains the FTE level at 120 in FY 2004.

President's Management Agenda

AoA is committed to advancing the President's Management Agenda (PMA) and has established measurable performance goals in each of the five identified areas. These goals are included in the Government Performance and Results Act (GPRA) performance plan and are consistent with the requirements of the PMA and the interests and needs of HHS for management improvement. AoA has already taken a number of steps to implement the PMA:

- Strategic Management of Human Capital: AoA has implemented a restructuring plan that reduces the organizational structure to three layers and reduces the number of supervisory positions without displacing employees. Along with these changes, AoA has achieved two additional measurable goals: reducing the average grade to less than 13.4 (mathematical average, not step), and increasing the ratio of employees to supervisors to better than 4.8 to 1. Consistent with the restructuring plan, AoA will develop a recruitment and retention plan that carries such achievements into the future while filling skill gaps in critical program areas.

- Competitive Sourcing: AoA has a rich tradition of competitively sourcing many aspects of both administrative and program support. AoA leverages resources by outsourcing most administrative functions including human resources, financial management, and acquisitions. In FY 2002, AoA began the process of competitively sourcing many of our public inquiry information resources functions.
- Improved Financial Performance: Although not required to do so by the Chief Financial Officers Act, AoA has subjected its financial statements to audits for the past two years. In both years, AoA received a clean opinion and no material weaknesses were identified. These two measurable elements are the principal PMA objectives for financial performance. In future years AoA will participate in Departmental "top-down" audits. AoA is also a full partner in the HHS effort to develop a Unified Financial Management System (UFMS).
- Expanded E-Government: In concert with HHS' lead role in the Federal government's E-Grants process, AoA has initiated work to apply E-Government solutions to its grants processing efforts, and will continue to work with State and local government entities to leverage such technologies for the submission of grant applications and detailed program information requirements. As a result of this key E-Government effort, AoA began processing electronic applications for grants and cooperative agreements in FY 2002. AoA is also a member of the HHS Small OPDIV IT Consolidation Consortium and will continue to work with the Department on E-Government initiatives, including the 24 government-wide initiatives identified as supporting the President's Management Agenda.
- Budget and Performance Integration: AoA has developed a comprehensive GPRA plan that addresses the goals and objectives of its program areas and exhibits strong linkages to the budget request. The plan reduces the overall number of measures by 15% while increasing the number of outcome measures (to 75% of the total number of measures). AoA began conducting six national surveys in 2002 to specifically measure program performance outcomes under GPRA.

Home and Community-Based Supportive Services

Authorizing Legislation: Section 321 of the Older Americans (OAA) Act of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$356,981,000	\$357,000,000	\$357,000,000	--

Home and Community-Based Supportive Services programs support a variety of activities that enable older Americans to remain in their homes and communities, including transportation services, information and assistance, personal care services, and other supporting services provided through senior centers and other community-based settings. This program helps to ensure that older Americans receive the services they need to remain independent.

Rationale for the Request

The FY 2004 request for Home and Community-Based Supportive Services (HCBSS) is \$357,000,000, which maintains the resource level requested in the FY 2003 President's budget. This funding, along with continued leveraging of funds at the State and local levels, should allow aging service providers, including senior centers which serve as community focal points to coordinate and integrate services for the elderly, to maintain current levels of service.

The number of older Americans is growing, and the population age 85 and over is growing faster than any other age cohort. Most of these older individuals want to live independently in their homes and communities. Yet nearly 2.2 million elders have severe long-term disabilities and require assistance with activities of daily living in order to avoid costly institutionalization. Compounding these needs, recent trends including earlier discharge from medical centers, increased use of outpatient and ambulatory care, and an increased reliance upon assistive medical technology often also result in older persons needing post-acute assistance in their own homes. The May 1999 General Accounting Office report, *Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services*, states "obtaining personal care on what is often a daily basis is critical for avoiding institutionalization.... without help from family, friends, or public programs, affording such assistance may be problematic".

Across the nation, and particularly in rural areas, aging service providers and older Americans alike emphasize the importance of transportation services in enabling elders to remain in their own homes and communities. AARP's *Community Transportation Survey* states that "86% of non-drivers report they do not use public transportation.... 50% of non-drivers say they cannot walk to a bus stop and 53% of non-drivers say they cannot walk to a grocery store". HCBSS programs provide for transportation services

which support one of life's most fundamental activities – mobility. Without transportation assistance, many older Americans are not able to see their doctors, get prescriptions filled, shop for groceries, or conduct other activities of daily living essential for independence and well-being.

Information and referral, another critical community-based access service, is the gateway to programs and services for America's elderly. Over 13 million seniors, family members, and friends received service and program information in FY 2001. Information and referral services empower individuals to make informed choices about their care, reduce abuse of the system by making it easier for consumers to access information, and save money by delaying or eliminating seniors' need to access other costlier forms of care.

HCBSS programs also support a variety of activities that enable older Americans to remain in their homes and communities. Personal care services offer in-home assistance to persons with the inability to perform one or more of the following activities of daily living: eating, dressing, bathing, toileting, transferring in and out of bed/chair or walking. Homemaker services provide assistance to persons with the inability to perform one or more of the following instrumental activities of daily living: preparing meals, shopping for personal items, managing money, using the telephone or doing light housework. Chore services provide assistance to persons having difficulty with one or more of the following instrumental activities of daily living: heavy housework, yard work or sidewalk maintenance. Adult day care/adult day health services provide personal care for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four hour day. Finally, case management services provide assistance in circumstances where an older person or their caregiver is experiencing diminished functioning capacities, personal conditions or other characteristics that require services by formal service providers. Activities of case management include assessing needs, developing care plans, authorizing services, arranging services, coordinating the provision of services among providers, follow-up, and reassessment, as required.

A Program Assessment Rating Tool (PART) review which included this program was conducted and helped to inform the FY 2004 budget policy. A summary of the PART assessment appears on page 11. Additional information about performance outcomes for this program is included in the GPRA performance plan and report which accompanies this budget request. The GPRA plan reflects a number of the corrective actions sought in the PART assessment including the identification of measurable strategic goals, the identification of more challenging performance targets, and the presentation of initial outcome data.

Purpose and Method of Operations

Formula grants are allocated to States based on their share of the population aged 60 and over. States provide funds to Area Agencies on Aging, that in turn fund local agencies and service providers. HCBSS enable older adults to remain as independent

as possible while residing in their homes and communities. Three categories of services are funded:

- *Access Services:* such as transportation, information and referral, case management, escort and outreach. Transportation is one of the most used – and most needed – services, with nearly 40 million one-way trips provided in FY 2001.
- *In-Home Services:* including chore, homemaker, personal care, home repair and rehabilitation services. Over 22 million hours of homemaker and personal care services, including assistance with cooking, bathing, and eating were provided to approximately 260,000 older persons in FY 2001.
- *Community Services:* including adult day care, health promotion and fitness programs. Over 10 million hours of adult day care were provided to over 45,000 older Americans in FY 2001.

In FY 2001, nearly seven million clients (both registered and unregistered persons receiving both registered and unregistered services) were served through the aging network. Three million of these elderly individuals are registered clients receiving intensive in-home services, including meals, from the aging network.

Of the almost seven million clients, almost 30% had incomes below the poverty level, almost 19% were minority elders, and approximately 30% lived in rural areas. The GPRA performance plan and report that accompanies this budget request provides additional information about the aging network's efforts to target funding to, and coordinate an array of services for, the most vulnerable older individuals.

Funding for Home and Community-Based Supportive Services during the past five years is as follows:

FY 1999	\$309,957,000
FY 2000	\$310,020,000
FY 2001	\$325,057,000
FY 2002	\$356,981,000
FY 2003	\$357,000,000

National Family Caregiver Support Program

Authorizing Legislation: Sections 371 and 631 of the Older Americans Act (OAA) of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$141,492,000	\$141,500,000	\$141,500,000	--

Families, not social service agencies or government programs, are the major providers of long-term care in this country. Estimates of the number of caregivers of elderly individuals run between 7 million and 55 million. Informal caregivers (spouses, adult children, other relatives, and friends) assist 95% of disabled older persons who need help to live in the community and are the sole source of assistance for almost two-thirds of these older persons. This informal care, if provided by home care aides, would cost \$257 billion per year.

Rationale for the Request

The FY 2004 request for the National Family Caregiver Support Program (NFCSP) is \$141,500,000, which maintains the resource level requested in the FY 2003 President's budget. Of this total, \$5,500,000 is maintained for the Native American Caregiver Support Program. This funding, along with continued leveraging of funds at the State and local levels, should allow States to maintain current levels of service.

Family caregivers provide an invaluable resource to their loved ones as well as to America. AoA is leading the Department's efforts to assist caregivers and provide them with resources in their communities. Families, not social service agencies, nursing homes, or government programs, are the mainstay of long-term care for older persons in the United States. A study in the journal *Health Affairs* valued the contribution of America's caregivers to the nation at \$257 billion annually. Caregiver services significantly reduce costs to Medicare, Medicaid, and private payers. The NFCSP, for a minimal cost, provides information, assistance, counseling, respite, and supplemental services that support the efforts of America's caregivers. This support allows the caregiver's loved one to remain at home for as long as possible.

Changing aspects of our society such as increased population longevity and different family patterns are placing greater pressure on caregivers. Lengthening life spans mean that the population age 85 and over has grown and will continue to grow faster than any other population cohort, increasing by 50 percent from 1996 to 2010. With advanced age comes an increase in chronic disease leading to significantly higher disability levels and therefore greater need for assistance.

While the U.S. population is aging, the structure of the American family continues to evolve. More women are in the workforce, making it more difficult for them to be available as caregivers; family mobility has increased, thus geographically separating older family members from younger ones; and family size has decreased, resulting in fewer adult children being available to serve as caregivers. Thus, fewer family members will increasingly share caregiving responsibilities. Research has shown that providing care to older persons exacts a heavy emotional, physical and financial toll.

- Half of all caregivers of older persons are over the age of 65, and thus are vulnerable to a decline in their own health. In fact, one-third of caregivers of older persons describe their own health as fair to poor;
- Because primary caregivers are emotionally strained, they have a high rate of depression. Numerous studies show that caregivers are significantly more depressed than age-matched controls in the general population;
- Almost one-third of caregivers are employed full-time, and most of these caregivers have experienced conflicts that require them to rearrange their work schedules, work fewer hours or take an unpaid leave of absence.

Research also indicates that informal caregiving supports have a significant impact on the status of caregivers and delay the need for nursing home services. For example, a recent NIH study, *Stress Reduction for Family Caregivers: Effects of Adult Day Care Use*, found that the provision of adult day care not only reduces caregiver stress but delays institutionalization of the care recipient. Another recent study, *Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease*, indicates that counseling and support for caregivers of individuals with Alzheimer's disease can permit the care recipient to stay at home an additional year before being admitted to a nursing home.

Until FY 2001, the first year of the NFCSP, public financing had been directed primarily to support formal services for older individuals. It had not provided an organized response to help maintain and sustain the efforts of caregivers.

A Program Assessment Rating Tool (PART) review which included this program was conducted and helped to inform the FY 2004 budget policy. A summary of the PART assessment appears on page 11. Additional information about performance outcomes for this program is included in the GPRA performance plan and report which accompanies this budget request. The GPRA plan reflects a number of the corrective actions sought in the PART assessment including the identification of measurable strategic goals, the identification of more challenging performance targets, and the presentation of initial outcome data.

Purpose and Method of Operations

In FY 2004, the NFCSP includes two components: \$136,000,000 for formula grants to States as authorized under Title III-E of the Older Americans Act, and \$5,500,000 for the Native American Caregiver Support Program as authorized under Title VI-C of the Older Americans Act. Consistent with the authorizing legislation, no funding is set aside in FY 2004 for either Competitive Grants, Demonstrations, and Research or Activities of National Significance.

Formula grant funds are distributed to States and Tribes based on their share of the population aged 60 and over. The NFCSP establishes a multifaceted support system in each State for family caregivers. All States have put in place five basic system components:

- Individualized information on available resources to support caregivers;
- Assistance to families in locating services from a variety of private and voluntary agencies;
- Caregiver counseling, training and peer support to help them better cope with the emotional and physical stress of dealing with the disabling effects of a family member's chronic condition;
- Respite care provided in the home, an adult day care center or over a weekend in a nursing home or residential setting such as an assisted living facility; and
- Limited supplemental services to fill service gaps that cannot be filled in any other manner.

In these early years of program implementation, AoA has focused on the fundamental need to identify and provide services to caregivers. Preliminary data provided to AoA by State agencies indicates that the network has exceeded the legislative target of serving 250,000 caregivers in FY 2002. Preliminary estimates indicate that States have provided direct services to a minimum of 275,000 caregivers in FY 2002. The GPRA performance plan and report that accompanies this budget request provides additional information about the aging network's efforts to increase the numbers of caregivers served and improve the quality of services provided.

Funding for the National Family Caregiver Support Program during the past three years is as follows:

FY 2001	\$124,981,000
FY 2002	\$141,492,000
FY 2003	\$141,500,000

Congregate Nutrition Services

Authorizing Legislation: Section 331 of the Older Americans (OAA) Act of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$390,000,000	\$390,000,000	\$390,000,000	--

Millions of older adults are malnourished. Adequate nutrition is essential for healthy aging and the prevention or delay of chronic disease and disease-related disabilities. Congregate nutrition services significantly improve participants' health and prevent more costly interventions. In addition, congregate nutrition services allow older people the opportunity to engage in social activities that contribute to their well-being.

Rationale for the Request

The FY 2004 request for Congregate Nutrition Services is \$390,000,000, which maintains the resource level requested in the FY 2003 President's budget. This funding, along with continued leveraging of funds at the State and local levels, should allow States to continue to serve the same number of meals to at-risk elders.

Scientific evidence indicates that adequate nutrition is necessary to maintain cognitive and physical functioning, to reduce chronic disease and disease-related disability, and to sustain a good quality of life. However, millions of older adults lack access to adequate amounts and quality of food necessary to sustain health and decrease the risk of disability. Provision of congregate meals helps to improve overall health status and to prevent older adults from having to choose between food and medications.

Researchers have concluded that individuals of any age can improve their health status and reduce the risk of disability if they institute lifestyle changes such as improved dietary habits. The *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity 2001* summarizes the health risks associated with being overweight or obese, including increased risk of diabetes, heart disease, stroke, hypertension, gallbladder disease, osteoarthritis, cancer, and high blood cholesterol. Changing lifestyle behaviors in the areas of nutrition and physical activity can help reduce weight and decrease the risk of these chronic diseases. *Serving Elders at Risk*, a national evaluation of AoA nutrition programs, indicates that congregate nutrition programs are effective in improving nutritional status, as well as in increasing social interaction, thereby improving overall health of participants. The congregate nutrition program provides an opportunity to implement interventions to address these issues

through healthy meals, nutrition education and counseling and linkages to physical activity programs.

The congregate meals program serves older adults who are at higher risk than the overall older population. It is the primary source of food and nutrients for many participants, and it presents opportunities for active social engagement and meaningful volunteer roles. Nutrition services are an essential part of health promotion and disease prevention activities and thereby contribute to the achievement of several Departmental initiatives, including the Healthy People 2010 goal of increasing the quality and years of healthy life.

A Program Assessment Rating Tool (PART) review which included this program was conducted and helped to inform the FY 2004 budget policy. A summary of the PART assessment appears on page 11. Additional information about performance outcomes for this program is included in the GPRA performance plan and report which accompanies this budget request. The GPRA plan reflects a number of the corrective actions sought in the PART assessment including the identification of measurable strategic goals, the identification of more challenging performance targets, and the presentation of initial outcome data.

Purpose and Method of Operations

Formula grants are allocated to States based on their share of the population aged 60 and over. States provide funds to Area Agencies on Aging, that in turn fund local agencies and service providers.

Congregate meals comply with the Dietary Guidelines for Americans and provide a minimum of 33% of the Recommended Dietary Allowances (RDA), as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Emerging scientific evidence now relates specific nutrient intake not only to preventing deficiency and maintaining physical and cognitive functioning but also to preventing disease and promoting health. Although meals are the core service, nutrition programs also provide related services such as nutrition screening, assessment, education, and counseling.

Priority for the receipt of nutrition services is given to those who are in greatest economic or social need with particular attention to older adults who are low-income, minority, or reside in rural areas. *Serving Elders at Risk* found that the congregate nutrition program serves older adults who are poorer, older, more likely to live alone, are in poorer health, poorer nutritional status, more functionally impaired, and more likely to be minorities than the general U.S. population. More recent program data shows that the program serves a greater proportion of rural elders than is reflected in the general older population. State data for FY 2001 indicate that approximately 112 million meals were served to older Americans.

There is substantial private sector, State, and local community financial and volunteer support in the Congregate Nutrition Program. Although there are no fees or charges for participation in this program, older persons are encouraged to contribute by being volunteers and by offering financial support to help defray the cost of services. The GPRA performance plan and report that accompanies this budget request provides additional information about the aging network's efforts to target services to individuals at greatest need and leverage funding from non-federal sources.

Funding for Congregate Nutrition Services during the past five years is as follows:

FY 1999	\$374,261,000
FY 2000	\$374,336,000
FY 2001	\$378,356,000
FY 2002	\$390,000,000
FY 2003	\$390,000,000

Home-Delivered Nutrition Services

Authorizing Legislation: Section 336 of the Older Americans (OAA) Act of 1965, as amended

	FY 2002 <u>Actual</u>	FY 2003 President's <u>Budget</u>	FY 2004 <u>Estimate</u>	Increase/ <u>Decrease</u>
BA	\$176,500,000	\$178,500,000	\$178,500,000	--

Millions of older adults are malnourished. Adequate nutrition is essential for healthy aging and the prevention or delay of chronic disease and disease-related disabilities. Home-delivered meals enable older adults to avoid or delay costly institutionalization, allowing them to stay in their homes and communities.

Rationale for the Request

The FY 2004 request for Home-Delivered Nutrition Services is \$178,500,000, which maintains the resource level requested in the FY 2003 President's budget. This funding, along with continued leveraging of funds at the State and local levels, should allow States to continue to serve the same number of meals to at-risk elders in their homes.

Scientific evidence indicates that adequate nutrition is necessary to maintain cognitive and physical functioning, to reduce chronic disease and disease-related disability, and to sustain a good quality of life. However, millions of older adults lack access to the quantity and quality of food necessary to maintain health and to decrease the risk of disability. Provision of home-delivered meals helps to improve overall health status and to prevent older adults from having to choose between food and medications.

Half of all persons age 85 and over are in need of assistance with activities of daily living, including obtaining and preparing food. Recipients of home-delivered meals are typically older persons who live alone, have annual incomes below \$10,000, and have multiple chronic health conditions. According to *Serving Elders at Risk*, a national evaluation of AoA nutrition programs, home-delivered nutrition services successfully target seniors who are older, poorer, more likely to live alone, more likely to live in rural areas, more likely to be minorities, are sicker, more functionally impaired, and at higher nutritional risk than those in the general US population.

With advanced age comes an increase in chronic diseases and disease-related disabilities, many of which are nutrition related. Home-delivered nutrition services play an important role in treating and managing, and in delaying the onset of, chronic disease and disease-related disability. In addition, home-delivered meals provide an essential service to many caregivers by helping them maintain their own health and well

being. Nutrition services also assist in decreasing the risk of complications associated with acute and chronic disease and contribute to improvements in quality of life.

Home-delivered meals are often the first in-home service that an older adult receives and the program serves as a primary access point for all other in-home services. A primary source of program referrals is the medical community, especially after hospital discharge. Forty-eight percent of home-delivered meals participants have spent time in a hospital or nursing home during the past year. However, older adults receiving home-delivered meals have half the length of hospital stay of those who did not receive home-delivered meals.

A Program Assessment Rating Tool (PART) review which included this program was conducted and helped to inform the FY 2004 budget policy. A summary of the PART assessment appears on page 11. Additional information about performance outcomes for this program is included in the GPRA performance plan and report which accompanies this budget request. The GPRA plan reflects a number of the corrective actions sought in the PART assessment including the identification of measurable strategic goals, the identification of more challenging performance targets, and the presentation of initial outcome data.

Purpose and Method of Operations

Formula grants are allocated to States based on their share of the population aged 60 and over. States provide funds to Area Agencies on Aging, that in turn fund local agencies and service providers.

Home-delivered meals comply with the Dietary Guidelines for Americans and provide a minimum of 33% of the Recommended Dietary Allowances (RDA), as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Emerging scientific evidence now relates specific nutrient intake not only to preventing deficiency and maintaining physical and cognitive functioning but also to preventing disease and promoting health. The Home-Delivered Nutrition Program promotes the delivery of culturally appropriate nutrition services in local communities, supports caregivers, provides social contact to home-bound older individuals who are at increased risk of depression and isolation and improves the dietary intakes of participants. Although meals are the core service, nutrition programs provide related services such as nutrition screening, assessment, education, and counseling.

Home-delivered nutrition services are provided to persons age 60 and older that are homebound due to illness, disability, or geographic isolation. Priority is given to those who are in greatest economic or social need with particular attention to low-income and minority older adults as well as individuals residing in rural communities. *Serving Elders at Risk* found that the home-delivered nutrition program serves older adults who are poorer, older, more likely to live alone, in poorer health, in poorer nutritional status, more functionally impaired, and more likely to be minorities than the general U.S. population. The evaluation also found that when compared to a comparable population,

participants in the home-delivered nutrition program had more social interactions contributing to improved quality of life. More recent program data shows that the program serves a greater proportion of rural elders than is reflected in the general older population. State data for FY 2001 indicate that approximately 144 million meals were served to over 928,000 older adults.

There is substantial private sector, State, and local community financial and volunteer support for the Home-Delivered Nutrition Program. Funding for the program is significantly leveraged and about 70 percent of its funding comes from sources other than the Older Americans Act. Although there are no fees or charges in this program, older persons are encouraged to contribute by serving as volunteers and by providing financial support to help defray the cost of services. The GPRA performance plan and report that accompanies this budget request provides additional information about the aging network's efforts to target services to individuals at greatest need and leverage funding from non-federal sources.

Funding for Home-Delivered Nutrition Services during the past five years is as follows:

FY 1999	\$112,000,000
FY 2000	\$146,970,000
FY 2001	\$151,978,000
FY 2002	\$176,500,000
FY 2003	\$178,500,000

Nutrition Services Incentive Program

Authorizing Legislation: Section 311 of the Older Americans (OAA) Act of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$149,670,000	\$149,670,000	\$149,670,000	--

Millions of older adults are malnourished. Adequate nutrition is essential for healthy aging and the prevention or delay of chronic disease and disease-related disabilities. The Nutrition Services Incentive Program provides additional funding to States which is dedicated exclusively to the provision of meals.

Rationale for the Request

The FY 2004 request for the Nutrition Services Incentive Program is \$149,670,000, which maintains the resource level requested in the FY 2003 President's budget. In response to feedback from our partners in the States and in the aging network, the FY 2004 budget modifies the proposal in the previous year's request by proposing to transfer the program intact from the Department of Agriculture (USDA) to AoA rather than consolidating the funding into AoA's existing nutrition programs. AoA will work with USDA to ensure that States that wish to receive commodities in lieu of cash may continue to do so.

Scientific evidence indicates that adequate nutrition is necessary to maintain cognitive and physical functioning, to reduce chronic disease and disease-related disability, and to sustain a good quality of life. Researchers have concluded that individuals of any age can improve their health status and reduce the risk of disability if they institute lifestyle changes such as improved dietary habits. Unfortunately, millions of older adults lack access to adequate amounts and quality of food necessary to sustain health and decrease the risk of disability.

Serving Elders at Risk, a national evaluation of AoA nutrition programs, indicates that these programs are effective in improving nutritional status, as well as in increasing social interaction, thereby improving overall health of participants. These program serve older adults who are at higher risk than the overall older population and are the primary source of food and nutrients for many participants.

Funds provided under the Nutrition Services Incentive Program are dedicated exclusively to the provision of meals. The program also gives States the option to receive commodities in lieu of cash if they determine that doing so will enable them to better serve the needs of seniors.

Purpose and Method of Operations

Formula grants are allocated to States based on the number of meals served in the prior year. States provide funding to Area Agencies on Aging, which in turn fund local agencies and service providers. The program gives States the option to receive all or part of their allocation as commodities in lieu of cash. AoA will work with USDA to ensure that States that wish to receive commodities in lieu of cash may continue to do so.

OAA nutrition programs comply with the Dietary Guidelines for Americans and provide a minimum of 33% of the Recommended Dietary Allowances (RDA), as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Priority for the receipt of nutrition services is given to those who are in greatest economic or social need with particular attention to low-income and minority older adults as well as individuals residing in rural communities. *Serving Elders at Risk* found that the OAA nutrition programs serve older adults who are poorer, older, more likely to live alone, in poorer health, in poorer nutritional status, more functionally impaired, and more likely to be minorities than the general U.S. population.

There is substantial private sector, State, and local community financial and volunteer support for the OAA nutrition programs. Funding for these programs is significantly leveraged and much of it comes from sources other than the OAA. Although there are no fees or charges, older persons are encouraged to contribute by serving as volunteers and by providing financial support to help defray the cost of services. The GPRA performance plan and report that accompanies this budget request provides additional information about the number of meals served each year and the aging network's efforts to leverage funding from non-federal sources.

Comparable funding for the Nutrition Services Incentive Program during the past five years is as follows:

FY 1999	\$140,000,000
FY 2000	\$139,930,000
FY 2001	\$150,000,000
FY 2002	\$149,670,000
FY 2003	\$149,670,000

Preventive Health Services

Authorizing Legislation: Section 361 of the Older Americans Act (OAA) of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$21,123,000	\$21,562,000	\$21,562,000	--

Chronic diseases are among the most prevalent, costly, and disabling of all health problems affecting older Americans. As the 76 million baby boomers age, the number of elderly Americans affected by chronic diseases will undoubtedly rise. Adopting health-promoting behaviors and lifestyles can prevent or delay the onset of chronic disease and reduce the likelihood of physical impairment.

Rationale for the Request

The FY 2004 request for Preventive Health Services is \$21,562,000, which maintains the resource level requested in the FY 2003 President's budget. This funding, along with continued leveraging of funds at the State and local levels, should allow AoA and the aging network to continue to focus on efforts to educate older Americans about, and move them towards, healthier lifestyles.

Although health problems are often viewed as inevitable in old age, a substantial number of chronic illnesses in the elderly are either preventable or controllable. Preventive Health Services encourage older persons to adopt healthy lifestyles that improve their quality of life and reduce the incidence of costly and debilitating illnesses. These low-cost programs educate older Americans about good health care practices and help to identify conditions, such as hypertension, high cholesterol levels, and elevated blood sugar levels, that if left untreated could lead to more serious illnesses and hospitalizations. Modifying certain risky behaviors, even in later life, can improve health and reduce the likelihood of chronic disease.

Americans are leading longer and more active lives. Gains in U.S. life expectancy have increased from an average lifespan of less than 50 years at the turn of the 20th century to more than 76 years today. These gains are largely attributable to advances in public health and medical care. The increase in longevity, however, brings a higher probability of developing a chronic condition. As more people live longer, the number of older Americans who suffer from chronic diseases and conditions, such as arthritis, cardiovascular disease, obesity and diabetes is also rising. Older Americans with chronic problems suffer from long-term pain, disability, a significant decrease in their quality of life, and frequent depression. Twenty-seven percent of women ages 65 to 85 suffer from two chronic conditions and nearly one-fourth of older women suffer from

three or more. Chronic diseases are expensive, accounting for three-fourths of all national health care costs.

AoA has partnered with the Centers for Disease Control and Prevention (CDC) to address significant problems affecting older Americans, such as diabetes, cardiovascular disease, and the need for immunization. Through an intra-agency agreement, AoA administers four demonstration grants to community coalitions to plan initiatives aimed at reducing the high rates of diabetes and cardiovascular disease and increasing the rates of adult immunizations in needy populations. In addition, AoA is engaging its extensive aging network of State and local aging organizations, public and private sector health associations, and voluntary organizations to help educate older Americans on how to lessen or prevent the negative impact that can result from chronic conditions and diseases, with particular emphasis on diabetes, obesity, and asthma.

In FY 2004, AoA will partner with CDC and other agencies on a new Department-wide Disease Prevention Initiative targeted to obesity, diabetes, and asthma. Research reveals these conditions are growing problems among for older adults. For instance: 15%-23% of the adults over 60 are obese; diabetes is the sixth leading cause of death for persons aged 65 years or older; and 2 million people age 65 and older have asthma. AoA will work with CDC and others to target competitive education and health promotion grants in nutrition, diabetes, and asthma to organizations that serve older individuals. These efforts will include an emphasis on reaching out to ethnic and minority elders with high incidences of chronic illnesses.

The FY 2004 request maintains the \$5 million earmark for medication management, screening and education activities. People aged 65 years and older take the greatest number and quantity of medications. Of elderly patients taking three or more prescription drugs for chronic conditions, more than one-third are re-hospitalized within 6 months of discharge, with 20 percent of the readmissions due to medication problems. Twenty-eight percent of hospitalizations of older people are due to noncompliance with drug therapy and adverse events. The risk of adverse reactions may be exacerbated by the physiological changes associated with aging, other health problems, or by drug interactions resulting from taking multiple medications. Moreover, older adults are more likely to suffer from multiple chronic diseases and, as a result, may routinely visit multiple physicians, each of whom may be unaware of other medicines that have been prescribed. Medication management activities help prevent incorrect medication and adverse drug reactions, and reduce unnecessary hospitalizations and illnesses, by teaching older adults about how to manage medications safely.

Purpose and Method of Operations

Formula grants are allocated to States based on their share of the population aged 60 and over. States provide funds to Area Agencies on Aging, that in turn fund local agencies and service providers. Preventive Health Services support mental and physical health promotion and disease prevention activities. Preventive Health Services

activities are part of a comprehensive and coordinated service system targeted to those elders most in need and living in medically underserved areas of the State.

Activities are carried out under Preventive Health Services through a variety of venues. These include group activities and programs offered at congregate meal sites and senior centers, as well as individualized counseling through programs such as case management and home-delivered meals. In many cases, AoA funds have leveraged considerable local money to carry out special programs that meet the unique health promotion and disease prevention needs of older people in their communities. The GPRA performance plan and report that accompanies this budget request provides additional information about the Aging Network's efforts to target services and leverage funding from non-federal sources.

Funding for Preventive Health Services during the past five years is as follows:

FY 1999	\$16,123,000
FY 2000	\$16,123,000
FY 2001	\$21,120,000
FY 2002	\$21,123,000
FY 2003	\$21,562,000

Program Innovations

Authorizing Legislation: Section 411 of the Older Americans Act (OAA) of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$38,257,000	\$27,837,000	\$27,837,000	—

Programs that successfully meet the needs of seniors and their families must be based on demonstrated results and outcomes. AoA awards competitive contracts and discretionary grants to fund projects that develop, initiate, and test promising practices to serve older persons and their families.

Rationale for the Request

The FY 2004 request for Program Innovations is \$27,837,000, the same as the FY 2003 President's budget. As in FY 2003, no funding is included in the FY 2004 request for one-time, one-year earmarks specified by Congress. The FY 2004 request builds on AoA's current efforts to maximize the value of available resources and better coordinate existing systems and services through projects that respond to the aging network's need to (1) develop integrated and more cost-effective systems of care; (2) develop new approaches to sustain the efforts of family and other informal caregivers and provide access to a combination of health and social supports; and (3) support collaborative efforts with other agencies both within and outside of HHS to deliver integrated services through the national aging network. The request also maintains support for ongoing projects, such as resource centers, that provide demonstrated benefits to elderly Americans and the programs that assist them.

Program Innovations provides AoA with the ability to be a catalyst for new and innovative approaches to meeting the needs of America's rapidly growing and increasingly diverse older population and their families. These funds have enabled AoA to develop, test and incorporate new ideas and approaches into national, State and local aging programs and provide much needed training and technical assistance to State and Area Agencies on Aging and Indian Tribes. AoA has used these funds to:

- develop and synthesize knowledge about aging from multidisciplinary perspectives;
- examine and test planning and practice models that improve or enhance services provided by the national aging network;
- evaluate the efficacy, quality, efficiency, and accessibility of programs and services for older individuals; and

- develop, implement, and evaluate innovative planning and practice strategies to address the needs, concerns, and capabilities of older individuals.

The FY 2004 request will utilize existing resources to support projects that build on current efforts to develop citizen-centered systems of long-term care, integrate access to care, and foster innovations in the provision of support to elders and family caregivers, such as:

- Promote and support the establishment of Aging "One-Stop Shop" Centers which will seek to eliminate the confusion and frustration people now face by serving as a visible and trusted resource where people can obtain objective information about their long-term care options. Centers will also provide information on best-practices and assist States to replicate the significant strides that a handful of States, such as Colorado, Oregon, Texas, Vermont, Washington, and Wisconsin, have made in creating more citizen-centered systems of care by reducing nursing home expenditures and increasing community-based choices, while containing costs.
- Create programs and policies that maintain and enhance the health status of older adults and provide opportunities for older adults to live independently in their own homes and communities as long as possible.
- Promote the health, security, independence, and dignity of older adults by developing culturally competent and effective models of home and community-based care that address the specific cultural needs of special populations such as ethnic minorities, women, low-income and rural families.
- Develop and advance new roles for older Americans that emphasize the productivity of older adults in our society, by conducting demonstrations and using applied research about factors contributing to successful aging to create programs and community education and development models.
- Identify and disseminate outcome measures appropriate for use with Older Americans Act and other aging network home and community-based care service programs.

AoA will also work with other agencies to highlight attention on osteoporosis prevention and treatment. It is estimated that eight million American women and two million American men have osteoporosis. An additional 18 million have low bone mass, placing them at increased risk for osteoporosis. Osteoporosis is responsible for more than 1.5 million fractures annually, and the Agency for Healthcare Research and Quality reports that in 1995, total direct medical expenditures in the United States for the treatment of osteoporotic fractures in adults older than 45 years was estimated at \$13.8 billion. The objective of the initiative will be to heighten awareness and promote behaviors that enhance bone health and to educate older persons, especially post-menopausal women, about the importance of diet, exercise, and bone density testing in the prevention of osteoporosis.

In addition, Program Innovations funding supports AoA's efforts to partner with other agencies inside and outside of HHS. Within HHS, AoA has worked with the Centers for Medicare and Medicaid Services (CMS); the Centers for Disease Control and Prevention (CDC); the National Institute on Aging; and with multiple agencies on the President's New Freedom Initiative, the Secretary's Rural Task Force, and the Department's Interagency Task Force on Aging. We are also working across Federal agencies, particularly with the Department of Transportation and the Department of Veterans Affairs, to further our advocacy work on behalf of the nation's elderly. These partnerships are a key component of AoA's effort to support older persons and their families. Some examples of these collaborations include:

- Systems Change: AoA is working with CMS, the Assistant Secretary for Planning and Evaluation, the Substance Abuse and Mental Health Services Administration, and other HHS agencies on efforts to help States redirect and integrate their systems of care to respond to older people's preference for care in the community. These efforts include collaborating on research projects to identify State trends in long-term care and to develop case studies on flexible service models that have been used by States to create more community options for older people; ensuring that the aging services network is involved in the Real Choice Systems Change Grants initiative; evaluating projects that promote "Aging In Place"; and promoting the use of Medicaid waivers and Consumer Directed Care models.
- Aging States Project: AoA is working with CDC to enhance communication and coordination between State Units on Aging and State Health Departments, and collaborating on a health promotion project targeting older adults. AoA and CDC pooled resources to support demonstration projects that promote physical activity, walking programs, and improved diet consistent with the President's Healthier US initiative; provide enhanced information on health promotion and physical activity to older individuals; and establish new statewide public health and aging network partnerships.
- USA on the Move: As part of the President's Healthier US Initiative, AoA is working in partnership with the National Policy and Resource Center on Nutrition and Aging to develop the USA on the Move: Steps to Healthy Aging initiative. This initiative is designed to improve nutrition and physical activity in older adults by working with State Units on Aging and local partners to disseminate information about simple and low cost ways to eat healthier and by promoting the use of step counters to inspire older adults to walk more.
- Quality of Care: AoA and CMS partnered to involve the Long-Term Care Ombudsmen program in CMS' Nursing Home Quality Indicator Initiative (QI). The goal of the QI initiative is to help consumers make informed nursing home placement and quality care decisions by providing them with objective indicators they can use to compare the quality of care in different nursing home facilities. The AoA/CMS partnership capitalizes on the vast experience of the over 8,000 certified volunteer

ombudsmen who help consumers to make decisions about nursing home placement and quality of care.

- Transportation: AoA and the Federal Transit Administration are partnering to increase coordination of transportation services for older adults. Transportation is a key to helping older people remain independent and in the community. The partnership involves collaboration in five areas: public awareness and outreach, data collection, technical assistance, stakeholder input, and promoting coordinated planning and funding at the State and local level. Activities will focus on disseminating information on "promising practices" in coordinated transportation services for the elderly, as well as conducting regional technical assistance sessions for State governments to promote models and approaches for coordinating transportation resources at the State level and local level.

In FY 2004 AoA will also continue to fund ongoing projects that provide demonstrated benefits to elderly Americans and the programs that assist them. These include:

- National Resource Centers: AoA supports several technical assistance programs to assist States, Area Agencies, and community providers with information, assistance, and services, involving either specific aging related issues or the needs of vulnerable subgroups of the elderly, including minority populations.
- Reducing Health Care Fraud, Waste and Errors: AoA and its network engage in coordinated outreach and targeted educational activities designed to test community-based models assisting older persons and their families to recognize and report Medicare fraud and prevent or minimize victimization of seniors and their families. Working with CMS, the Office of Inspector General, health care providers, and other professionals from around the country, AoA and its grantees have instituted educational activities nationwide.
- Promoting Intergenerational Opportunities: Family Friends/Volunteer Senior Aides: Linking older, caring senior volunteers with children suffering from chronic health conditions or disabilities whose families need support is the focus of another activity which has received ongoing funding under this program. This activity targets at-risk groups such as poor rural families in distress, families and children living in homeless shelters, families of babies who are HIV-positive, and at-risk families that need respite care. Funding supports a national technical assistance center as well as local projects.

In addition, this program funds Government Performance and Results Act and related evaluation activities and supports a cooperative effort between AoA and selected State and Area Agencies on Aging to develop and test outcome measures, various performance measurement instruments, and sampling methods that can be used to effectively and efficiently identify the results produced through OAA programs on an ongoing basis.

Purpose and Method of Operations

Competitive grants, cooperative agreements and contracts are awarded to eligible public or private agencies and organizations, State and Area Agencies on Aging, and other organizations representing and/or serving older people. Eligible entities include public and/or nonprofit agencies, organizations, including faith-based organizations, and institutions of higher learning. Grantees are required to provide a match equal to 25 percent of the project's total cost.

AoA's focus has been on projects that demonstrate new methods and practices to improve the quality and effectiveness of programs and services, evaluate existing programs and services, and train workers in the field of aging.

Since projects are designed to test and evaluate the efficacy of new approaches, each project that AoA funds includes an evaluation component. The results of these projects are disseminated through government information networks including AoA's Internet web site, AoA's aging network listserv, and the National Aging Information Center. Continued funding to develop and refine outcome measures is essential to AoA's success in fully implementing the requirements of GPRA.

Funding for Program Innovations during the past five years is as follows:

FY 1999	\$18,000,000
FY 2000	\$29,344,000
FY 2001	\$35,852,000
FY 2002	\$38,257,000
FY 2003	\$27,837,000

Aging Network Support Activities

Authorizing Legislation: Section 201, 202 and 215 of the Older Americans Act (OAA) of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$2,379,000	\$2,379,000	\$2,379,000	--

Aging Network Support Activities includes two long-standing programs – the Eldercare Locator and Pension Counseling – which provide information and assistance to seniors and their families.

Rationale for the Request

The FY 2004 request for Aging Network Support Activities is \$2,379,000, which maintains the resource level requested in the FY 2003 President's budget. The request includes funding for both the Eldercare Locator and the Pension Counseling program.

- Eldercare Locator

Older Americans and their caregivers face a complicated array of choices and decisions about their health care, pensions, insurance, housing, financial management, and long-term care. Changing benefits in public programs and an expansion of private sector services contribute to this confusing consumer climate. Also, the growing ethnically and culturally diverse population of older adults in America will require an ever increasing need for multilingual capability and cultural sensitivity among aging information programs.

The Eldercare Locator is a toll-free, nationwide directory assistance service that puts older adults and their caregivers in touch with services that enhance the well being of America's older citizens and those who care for them. Established as a public service by AoA, the Eldercare locator connects those who need assistance with State and local Area Agencies on Aging and private organizations that serve older adults and their caregivers. Whether an older person needing help with services such as meals, home care or transportation, or a caregiver needing training and education or a well-deserved break from caregiving responsibilities, the Eldercare Locator is there to point that person in the right direction.

- Pension Counseling

Statistics have shown that between one in five and one in seven persons have had their pension calculated incorrectly by their employer or their retirement plan. Given that there are over 750,000 different pension plans in force in the United States, and that any given employee may have worked for several employers, which may have merged, sold their plans, or gone bankrupt, it is very difficult for the average person to know

where to go to get help in finding out whether he or she is receiving all the benefits to which he or she is entitled.

Over the past ten years, AoA has run a pension counseling and information demonstration program with a total investment of approximately \$8 million. This program assists older Americans in accessing information about their retirement benefits and helps them negotiate with former employers or pension plans for due compensation. Projects reach out, educate, and promote pension awareness and protection among older individuals. This program has served over 13,000 people, mostly older people, their spouses or families, in 14 States and recouped approximately \$40 million in payments owed to retirees.

Purpose and Method of Operations

Competitive grants and contracts are awarded to eligible public or private non-profit agencies, community-based organizations, including faith-based organizations, State and Area Agencies on Aging, and other organizations representing and/or serving older people.

Funding for Aging Network Support Activities during the past three years is as follows:

FY 2001	\$1,812,000
FY 2002	\$2,379,000
FY 2003	\$2,379,000

Grants for Native Americans

Authorizing Legislation: Sections 613 and 623 of the Older Americans Act (OAA) of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$25,722,000	\$25,729,000	\$25,729,000	--

Greater numbers of Native Americans, Alaskan Natives and Native Hawaiians are living well into their eighties and nineties. AoA programs supply nutritional and supportive services to older Native Americans, Alaskan Natives, and Native Hawaiians, helping them to remain healthy and independent.

Rationale for the Request

The FY 2004 request for Grants for Native Americans is \$25,729,000, which maintains the resource level requested in the FY 2003 President's budget. This funding should allow tribal organizations to maintain current levels of service.

The 2000 Census identified nearly 213,000 American Indians and Alaskan Natives over the age of 60. A 1995 long-term care study supported by AoA, *Home and Community-Based Long Term Care in American Indian and Alaska Native Communities*, indicated that the need for home and community-based, long-term care services among Indian Tribes is extensive, but largely unmet. Tribal representatives participating in listening sessions have also voiced an interest in the types of services that AoA is able to provide and expressed the need for better coordination and collaboration in the provision of long-term care services.

Native Americans also suffer from high levels of disease such as obesity and diabetes. Researchers have concluded that lifestyle and dietary changes can help to prevent and/or treat these and other chronic conditions and reduce the risk of disability and complications. Continuing to provide services through AoA's Grants for Native Americans program is a smart, cost-effective way to meet tribal elders' needs while at the same time reducing the need for costlier institutional care.

AoA is working closely with Tribes and the organizations that provide services to them, including Native American Resource Centers, to better identify and meet the needs of older Native Americans. Some of these efforts include:

- Needs Assessment: The University of North Dakota's National Resource Center on Native American Aging worked with AoA to design and implement a needs assessment for Native American elders. Approximately 83 Tribes participated in the needs assessment. While data is now being generalized to the Native Elder

population, AoA is encouraging Tribes to use local level data for purposes ranging from grant applications to planning and documentation. The Tribes have been encouraged to share the findings and disseminate the results to alert people to their value. For example, the finding that Native American elders use far less alcohol than the national norms for all races is indeed positive news and should be broadcast.

- Native Hawaiian Health: Alu Like, a program grantee, is collaborating with the Native Hawaiian Health Care system to help Hawaiian elders maintain or improve their health. As a result of this collaboration elders will be offered routine health screenings and appropriate follow-up services. Dental, vision and hearing screenings will be offered when possible. Senior program staff will reinforce healthy habits through group exercises and discussions about nutrition. Each month elders will weigh in, take their blood pressure and answer questions about their exercise habits and fruit and vegetable intake for the past month. These measurements will be used to assess health outcomes.
- Native American Roundtable: AoA cosponsored a Roundtable on long-term care with the Indian Health Service and the National Indian Council on Aging. The roundtable included presentations addressing the needs of the Tribes and provided an opportunity for meaningful dialogue with Tribal participants. As a result of this roundtable, the Department is developing a better understanding of what long-term care looks like in Indian country today and what direction the Tribes would like to take in the future.

As part of ongoing outreach efforts to Tribes, AoA has also worked to increase the number of Tribal organizations receiving funding through the Grants to Native Americans program. In FY 2002, eight additional Tribal organizations began receiving funding through the program.

In seeking to address the needs of older Native Americans, AoA serves those in greatest need: A 1996 nutrition evaluation, *Serving Elders at Risk*, documented that more than 50% of Native American congregate meal participants had incomes at or below the poverty level and that the congregate meal was the major or only source of food for the day for 45% of participants. The evaluation also showed that 29% of the congregate meal participants and 28% of the home-delivered meal participants were older people living alone.

Purpose and Method of Operations

Funds for nutrition and supportive services grants to Native Americans are distributed to tribal organizations based on the American Indian or Alaskan Native elder population aged 60 and older. Nutrition services include both congregate and home-delivered meals. Supportive services include transportation, information and assistance, chore and homemaker services, health aide services and legal assistance. These services

are responsive to the cultural diversity of native communities and comprise a critical component of the communities' comprehensive services.

Grants to Native Americans also provide training and technical assistance to grantees through on-site visitation, telephone and written consultation, national meetings, and newsletters, as well as electronically by AoA staff, and through the Native American Resource Centers. This training and technical assistance is designed to further the development and strengthen the capacity of program directors and staff to enhance comprehensive and coordinated systems of nutritional and supportive services for American Indian, Alaska Native and Native Hawaiian elders.

In FY 2002, grants were awarded to 241 tribal organizations representing approximately 300 Tribes and two organizations serving Native Hawaiian Elders. The GPRA performance plan and report that accompanies this budget request provides additional information about the services provided in a number of different categories, including congregate and home-delivered meals, transportation, and in-home services.

Funding for Grants to Native Americans during the past five years is as follows:

FY 1999	\$18,457,000
FY 2000	\$18,457,000
FY 2001	\$23,457,000
FY 2002	\$25,722,000
FY 2003	\$25,729,000

Protection of Vulnerable Older Americans

Authorizing Legislation: Sections 702, 712, 721 and 731 of the Older Americans Act (OAA) of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$17,681,000	\$17,681,000	\$17,681,000	--

This program provides assistance to the most vulnerable older Americans to help them protect themselves from abuse and exploitation, to exercise control over their environment, and to locate the resources they need for care and daily living.

Rationale for the Request

The FY 2004 request for Protection of Vulnerable Older Americans is \$17,681,000, which maintains the resource level requested in the FY 2003 President's budget. The request includes funding for the Long-Term Care Ombudsman program and for the Prevention of Elder Abuse, Neglect, and Exploitation program. This funding should allow AoA to continue to support successful efforts to prevent the abuse, neglect, and exploitation of older individuals in institutional care settings as well as in their own homes and communities.

- Long-Term Care Ombudsman:

Preliminary data for FY 2001 indicate that nationwide elderly and disabled people reside in approximately 17,700 nursing homes with 1.8 million beds and 46,000 licensed board and care, assisted living and similar facilities, with approximately 967,000 beds. The Long-Term Care Ombudsman program helps States to investigate and resolve complaints made by, or on behalf of, residents of long-term care facilities related to action, inaction, or decisions that may adversely affect the health, safety, welfare, or rights of residents.

Thousands of certified ombudsman volunteers serve as "community extenders" by providing a community presence in long-term care facilities and by promoting positive culture change through the introduction of innovative approaches, such as those engineered by the Eden Alternative and others, to enliven and enhance residents' lives. A December 2000 Institute of Medicine report, *Improving the Quality of Long-Term Care*, noted the importance of the routine on-site presence of ombudsmen in establishing resident confidence in long-term care facilities and in detecting problems before they become serious. Ombudsmen train and provide technical assistance to facility managers and staff on alternatives to physical and chemical restraints, thus helping to meet the Center for Medicare and Medicaid Services (CMS) GPRA goal to reduce the use of such restraints in nursing homes.

FY 2001 preliminary data shows that ombudsmen investigated approximately 265,000 complaints made by over 150,000 individuals, an increase of approximately 11 percent over the number of cases and complaints handled in FY 2000. Approximately 77 percent of the complaints were resolved or partially resolved. Nationally, ombudsmen regularly visited approximately 85 percent of all nursing homes and 44 percent of all licensed board and care and similar facilities. In recent years, the foremost quality-of-care issues identified by ombudsmen were the need for increased numbers of trained staff to care for residents.

As part of the Department's efforts to improve the overall quality of care, AoA and CMS have partnered to involve the Long-Term Care Ombudsmen program in CMS' Nursing Home Quality Indicator Initiative (QI). The goal of the QI initiative is to help consumers make informed nursing home placement and quality care decisions by providing them with objective indicators they can use to compare the quality of care in different nursing home facilities. The AoA/CMS partnership capitalizes on the vast experience of the over 8,000 certified volunteer ombudsmen who help consumers make decisions about nursing home placement and quality of care.

- Prevention of Elder Abuse, Neglect, and Exploitation:

Each year hundreds of thousands of older persons are abused, neglected and exploited by family members and others. Many victims are people who are older, frail, and vulnerable and depend on others to meet their most basic needs. A 2000 survey of investigations conducted by adult protective services programs across the nation revealed a 61 percent increase over 1996 in the number of elder abuse allegations nationally – and a 300 percent increase since the first national survey in 1986. These statistics still underestimate the true extent of the problem; the 1998 National Elder Abuse Incidence Study found that for every confirmed case of domestic elder abuse reported to adult protective services in 1996, between four and five were not reported.

Elder abuse includes physical, sexual and psychological abuse as well as neglect and financial exploitation. Elder financial exploitation, in particular, is a growing problem. Frail and isolated seniors make tempting targets and are often over-represented on telemarketers lists. A *Journal of Consumer Affairs* survey of U.S. police departments found that 99% of home improvement scams were directed at older Americans, typically women 65 or older who lived alone. Exploitation crimes often cause seniors to lose their independence because many are unable to replace lost assets through work, saving, or investing.

As the effective and visible advocate for older Americans and their concerns, AoA is committed to protecting seniors from elder abuse. The Prevention of Elder Abuse, Neglect, and Exploitation program seeks to address the issues of elder abuse by providing training to aging professionals, disseminating critical information and supporting public education campaigns about the issue of elder abuse, and providing support to State and community programs that work to protect the rights of vulnerable, at-risk older persons. In addition, AoA supports a national clearinghouse of information

for professionals and the public which provides technical assistance and training to States and community-based organizations.

AoA also co-chairs the Elder Justice Interagency Working Group with the Department of Justice. This working group coordinates the federal response to elder abuse and is carrying out a national study on elder financial exploitation.

Purpose and Method of Operations

Formula grants are allocated to States based on their share of the population aged 60 and over. Funding supports both the Long-Term Care Ombudsman program and the Prevention of Elder Abuse, Neglect, and Exploitation program.

Funding for the *Long-Term Care Ombudsman* program is used to support statewide ombudsman activities, including staff salaries, volunteer support and training, travel, supplies and other basic operating costs. This program has traditionally focused on activities that protect and enhance the basic rights and benefits of the most vulnerable older adults. There are 53 State Long-Term Care Ombudsman programs that support ombudsman staff and volunteers in 596 local or regional programs. The GPRA performance plan and report that accompanies this budget request provides additional information about the role of Long-Term Care Ombudsmen in resolving complaints.

Funding for the *Prevention of Elder Abuse, Neglect, and Exploitation Program* supports a range of State and local activities. A 1991 report by the U.S. General Accounting Office found that public and professional education are the most effective means of identifying new cases of elder abuse. This program supports State and local efforts to train law enforcement officers, medical professionals and others in how to recognize and respond to these cases, and funds State and local elder abuse public awareness campaigns. This program also supports local multi-disciplinary teams that coordinate the response to abuse cases by law enforcement, medical professionals, and social and adult protective services workers.

Funding for Protection of Vulnerable Older Americans during the past five years is as follows:

FY 1999	\$12,181,000
FY 2000	\$13,179,000
FY 2001	\$14,181,000
FY 2002	\$17,681,000
FY 2003	\$17,681,000

Alzheimer's Disease Demonstration Grants

Authorizing Legislation: Section 398 of the Public Health Services (PHS) Act

	FY 2002 <u>Actual</u>	FY 2003 President's <u>Budget</u>	FY 2004 <u>Estimate</u>	Increase/ <u>Decrease</u>
BA	\$11,483,000	\$11,500,000	\$11,500,000	--

Alzheimer's disease exacts a heavy toll on its victims, their families, and our health care system. Each year new research helps to sharpen the effectiveness of care for people with Alzheimer's disease. The Alzheimer's Disease Demonstration Grants program helps States use this research to develop effective models of care for persons with Alzheimer's disease.

Rationale for the Request

The FY 2004 request for the Alzheimer's Disease Demonstration Grants program is \$11,500,000, which maintains the resource level requested in the FY 2003 President's budget. This funding, along with continued leveraging of funds at the State and local levels, should allow AoA to continue to support projects that demonstrate effective practices for serving persons with Alzheimer's disease and their families.

Alzheimer's disease, the most common cause of dementia among older persons, is evidenced by a progressive, irreversible decline in mental functioning. As the disease progresses, individuals with Alzheimer's disease experience a loss of memory and gradually lose their capacity to reason, communicate, and carry out the simple tasks of daily life such as brushing their teeth or combing their hair. At later stages, people with Alzheimer's disease may become anxious or aggressive, may wander away from home, and may eventually need total care. Alzheimer's disease is not only devastating to the individuals who have it, but seriously disrupts the lives of those who care for them.

Alzheimer's disease affects as many as four million Americans. Most people diagnosed with Alzheimer's disease are older than 65. However, it is possible for the disease to occur in people in their 40's and 50's. Recent research has shown links between some genes and Alzheimer's disease, but in about 90 percent of cases, there is no clear genetic link.

Alzheimer's Disease Demonstration Grants provide an important mechanism for the systematic application of research findings to the development and implementation of models of care for persons with Alzheimer's disease. AoA conducts a university-based evaluation of grantees each grant cycle, with the last report completed in 2001. Each year, approximately 5,500 families receive direct home and community-based services (home health care, adult day care, personal care, in-home respite care, companion care, and institutional respite). An additional 125,000 Alzheimer's families receive

support services such as case management, information and education, diagnostic and legal services. On average, Alzheimer's Disease Demonstration service recipients are approximately 80 years old; 64 percent are women; 48 percent live in rural areas; and 67 percent have incomes under \$15,000 per year. The program has also been successful in reaching ethnic and cultural minorities: 22 percent of those served are Hispanic/Latino; 15 percent are African American; 10 percent are Asian/Pacific Islander, and 0.5 percent are Native Americans. The average number of impairments in activities of daily living in Alzheimer's Disease Demonstration clients is 4.2, meaning that the population the program serves is similar in functional impairment to those who qualify for nursing facility care and Medicaid Home and Community Based Waiver programs in most States.

Additional analysis provides important information on the way in which families utilize services such as respite care. For instance, the evaluation showed that nearly one-third of all elders used respite care for only one or two months, while the average duration of use for long-term users of respite care was 16.2 months of use for day care clients and 14.9 months of use for in-home respite care. Day care clients used approximately 50.3 hours of day care per month, while in-home respite users used 24.6 hours per month. In addition, specific patterns were identified in the way various types of caregivers (i.e. spouses versus daughters) and various ethnic groups (Hispanic, African American and Caucasian) utilized respite care.

In a special initiative within the Alzheimer's Disease Demonstration program, AoA studied the impact of home and community-based services provided to Alzheimer's families who were participating in a managed health care plan. Study results indicated that the services provided through the Alzheimer's Disease Demonstration program significantly increased clients' satisfaction with their managed care organization and could lead to more appropriate use of primary and emergency care services. Thus, results from the Alzheimer's Demonstration Program not only have important implications for replication of successful strategies to serve Alzheimer's families, but the information is also instructive on how to enhance our capacity and effectiveness in reaching all families facing the challenges of aging, regardless of their culture, ethnicity, income, or geographic location.

Purpose and Method of Operations

The Alzheimer's Disease Demonstration Grants program provides funds to States to develop model practices for serving persons with Alzheimer's disease and their families. The central support services mandated by statute for the program are respite care, home health, personal care, companion care, day care, legal rights education, and information and counseling.

The Alzheimer's Disease Demonstration Grants program has four primary components:

- Development and operation of State Alzheimer's disease programs in coordination with organizations that provide diagnostic, treatment, care management, respite

care, legal counseling, and education services to individuals with Alzheimer's disease or related disorders;

- Provision of home care, personal care, day care, respite care and companion care services;
- Provision of information on Alzheimer's disease services, assistance, and legal matters; and,
- Improvement of access to home and community based long-term care services for persons with Alzheimer's disease and their families.

While AoA encourages targeting of program services to minority, low-income, and rural families, each grantee develops service and outreach programs that are specific to its unique needs and resources. State and local Alzheimer's Association chapters are active in all of the current projects.

Since its inception in 1992, the Alzheimer's Disease Demonstration Grants program has provided more than 15,000 families with home and community-based supportive services through the efforts of over 600 local agencies. In FY 2002, eight new grants were awarded, resulting in seven new States participating in the program and bringing the total number of States that have participated in the program to 42 (including the District of Columbia and Puerto Rico).

Funding for Alzheimer's Disease Demonstration Grants during the past five years is as follows:

FY 1999	\$5,970,000
FY 2000	\$5,968,000
FY 2001	\$8,962,000
FY 2002	\$11,483,000
FY 2003	\$11,500,000

Program Administration

Authorizing Legislation: Section 205 of the Older Americans Act (OAA) of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA	\$18,053,000	\$17,986,000	\$17,501,000	-\$485,000
FTE	120	120	120	--

The Administration on Aging is the Federal advocacy agency for older Americans and the lead Federal partner in the aging network. The aging network administers programs established under the Older Americans Act which support the well-being, health and independence of America's seniors. Investments in Program Administration insure that AoA will be able to increase the effectiveness of current services and lead the implementation of new aging initiatives.

Rationale for the Request

The FY 2004 request for Program Administration is \$17,501,000, which represents a reduction of -\$485,000 below the FY 2003 President's budget. The request maintains the FTE level at 120 in FY 2004 and includes an increase of +\$247,000 to partially offset the cost of projected pay increases.

The FY 2004 request continues support for the Unified Financial Management System (UFMS), which will be implemented to replace five legacy accounting systems currently used across the Operating Divisions. The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. It will also promote the consolidation of accounting operations and thereby reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable agencies and program administrators to make more timely and informed decisions regarding their operations. AoA requests \$163,000 to support this effort in FY 2004.

AoA's FY 2004 request includes funding to support Departmental efforts to improve the HHS Information Technology Enterprise Infrastructure. The request includes funds to support an enterprise approach to investing in key information technology infrastructure such as security and network modernization. These investments will enable HHS programs to carry-out their missions more securely and at a lower cost. Agency funds will be combined with resources in the Information Technology Security and Innovation Fund to promote collaboration in planning and project management and to achieve

common goals such as secure and reliable communication and lower costs for the purchase and maintenance of hardware and software.

The AoA budget request includes savings in the information technology (IT) budget from ongoing IT consolidation efforts, and additional reduced spending through the streamlining or elimination of lower priority projects. These savings total \$383,000. AoA is also participating in the consolidation of IT infrastructure support staff service across the eight smaller HHS Operating Divisions.

AoA's FY 2004 budget supports the President's Management Agenda (PMA) and includes \$349,000 in cost savings from consolidating administrative functions, organizational de-layering to speed decision making processes, competitive sourcing, implementation of effective workforce planning and human capital management strategies, and adoption of economies and efficiencies in contracting and other administrative operations. AoA is committed to advancing the PMA and has established measurable performance goals in each of the five identified areas. These goals are included in the Government Performance and Results Act (GPRA) performance plan and are consistent with the requirements of the PMA and the interests and needs of HHS for management improvement. AoA has already taken a number of steps to implement the PMA:

- Strategic Management of Human Capital: AoA has implemented a restructuring plan that reduced the organizational structure to three layers and reduced the number of supervisory positions without displacing employees. Along with these changes, AoA has achieved two additional measurable goals: reducing the average grade to less than 13.4 (mathematical average, not step), and increasing the ratio of employees to supervisors to better than 4.8 to 1. Consistent with the restructuring plan, AoA will develop a recruitment and retention plan that carries such achievements into the future while filling skill gaps in critical program areas.
- Competitive Sourcing: AoA has a rich tradition of competitively sourcing many aspects of both administrative and program support. AoA leverages resources by outsourcing most administrative functions including human resources, financial management, and acquisitions. In FY 2002, AoA began the process of competitively sourcing many of our public inquiry information resources functions.
- Improved Financial Performance: Although not required to do so by the Chief Financial Officers Act, AoA has subjected its financial statements to audits for the past two years. In both years, AoA received a clean opinion and no material weaknesses were identified. These two measurable elements are the principal PMA objectives for financial performance. In future years AoA will participate in Departmental "top-down" audits. AoA is also a full partner in the HHS effort to develop a Unified Financial Management System (UFMS).
- Expanded E-Government: In concert with HHS' lead role in the Federal government's E-Grants process, AoA has initiated work to apply E-Government

solutions to its grants processing efforts, and will continue to work with State and local government entities to leverage such technologies for the submission of grant applications and detailed program information requirements. As a result of this key E-Government effort, AoA began processing electronic applications for grants and cooperative agreements in FY 2002. AoA is also a member of the HHS Small OPDIV IT Consolidation Consortium and will continue to work with the Department on E-Government initiatives, including the 24 government-wide initiatives identified as supporting the President's Management Agenda.

- Budget and Performance Integration: AoA has developed a comprehensive GPRA plan that addresses the goals and objectives of its program areas and exhibits strong linkages to the budget request. The plan reduces the overall number of measures by 15% while increasing the number of outcome measures (to 75% of the total number of measures). AoA began conducting six national surveys in 2002 to specifically measure program performance outcomes under GPRA.

Purpose and Method of Operations

The Program Administration account funds salaries and related expenses which provide administrative and management support for all AoA programs. Allocations for the cost of rent, automated systems support, personnel services, travel, supplies, equipment and other costs are made to all headquarters and regional staff offices within AoA.

Effective December 31, 2001, AoA was restructured to focus on consumer needs and to better ensure positive outcomes for seniors. Under this new structure, AoA has four components in addition to the Office of the Assistant Secretary.

The *Center for Communication and Consumer Services (CCCS)* provides a central strategic focus for AoA's public information, education, consumer services and outreach activities.

The *Center for Planning and Policy Development (CPPD)* is responsible for analyzing trends in demographics and service needs and translating those trends into new policies and programs to assist the elderly. This center also administers the programs authorized under Title IV of the Older Americans Act (OAA) and Section 398 of the Public Health Service Act.

The *Center for Wellness and Community-Based Services (CWCBS)* focuses on topical areas of importance to the aging network and America's elderly population. Within this Center are three offices:

- The *Office for Community-Based Services* administers an array of programs that enable older people, their families and caregivers to remain independent and able to live in their own homes and communities. This office administers the programs authorized under Title III of the OAA.

- The *Office for American Indian, Alaskan Native, and Native Hawaiian Programs* provides leadership and coordination of activities, services and policies related to American Indians, Alaskan Natives and Native Hawaiian elders, and administers the programs authorized by Title VI of the OAA.
- The *Office of Consumer Choice and Protection* promotes good health practices and disease prevention, equips seniors with knowledge to make better consumer choices, and protects vulnerable seniors from abuses and exploitation. This office administers the programs authorized by Titles II and VII of the OAA as well as the Senior Medicare Patrol Project and activities funded under the Health Care Fraud and Abuse Control program.
- In addition, the CWCBS includes the *AoA Central Office Regional Support Center* that oversees and coordinates the activities of AoA's nine Regional Support Centers. These regional centers provide assistance to the AoA headquarters office in carrying out AoA's responsibilities under the OAA, and provide technical assistance to State, local and Tribal components of the national aging network.

The *Center for Management (CM)* is responsible for administrative activities that support AoA's policy, programmatic and information functions. Within CM, there are four offices:

- The *Office of Grants Management* distributes approximately 450 grants annually and works with grantees to ensure compliance with applicable laws and regulations for receipt of Federal funds.
- The *Office of Budget and Finance* performs budget formulation and execution and is responsible for formulating financial policies and procedures and for providing analysis of financial resources.
- The *Office of Information Resources Management* oversees all of AoA's information technology resources. AoA has seven automated computer systems, two of which are mission-critical grants management systems.
- The *Office of Administrative Services* provides support to AoA in the areas of personnel, acquisitions, management analysis, logistics, records management, and other administrative services.

Funding and FTE levels for Program Administration during the past five years is as follows:

FY 1999	\$14,781,000	120 FTE
FY 2000	\$16,458,000	119 FTE
FY 2001	\$17,216,000	120 FTE
FY 2002	\$18,053,000	120 FTE
FY 2003	\$17,986,000	120 FTE

White House Conference on Aging

Authorizing Legislation: Section 211 of the Older Americans (OAA) Act of 1965, as amended

	<u>FY 2002 Actual</u>	<u>FY 2003 President's Budget</u>	<u>FY 2004 Estimate</u>	<u>Increase/ Decrease</u>
BA*	\$0	\$0	\$2,842,000	+\$2,842,000

*The request for FY 2004 is for \$2,842,000 to be available until September 30, 2006.

This request is for funds to hold a White House Conference on Aging no later than December 31, 2005. This would be the first such Conference of the 21st Century, and the fifth in our nation's history.

Rationale for the Request

For FY 2004, \$2,842,000 is requested for start-up costs for a White House Conference on Aging to be held prior to December 31, 2005, as required by the Older Americans Act Amendments of 2000. This amount is part of a total of approximately \$8 million that is estimated to be needed to hold the Conference. AoA anticipates that various HHS Operating Divisions and other Departments will detail staff and/or provide in-kind assistance to supplement Congressional appropriations.

White House Conferences on Aging have served as catalysts for developing aging policy for the past 40 years. Past White House Conferences on Aging have prompted the development of many of the programs that represent America's commitment to the elderly. The recommendations made by these conferences have resulted in improvements in the programs which assist seniors and their families and led to better quality of life for older Americans.

Purpose and Method of Operation

A Policy Committee and its staff will administer all funding to carry out conference-related activities and will work closely with key cabinet agencies including HHS and the Departments of Education, Labor, Housing and Urban Development, Transportation, Treasury, Veterans Affairs and the Social Security Administration. HHS involvement and support could include the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Food and Drug Administration, the Health Resources and Services Administration, the National Institutes of Health, and the office of the Assistant Secretary for Planning and Evaluation.

There has been no funding in the last five years for a White House Conference on Aging.

1965

Administration on Aging Grants to States for Home and Community-Based Supportive Services

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
Total Amount.....	\$356,981,000	\$357,000,000	\$357,000,000	--
Alabama.....	5,691,588	5,643,481	5,643,481	--
Alaska.....	1,779,331	1,767,150	1,767,150	--
Arizona.....	6,488,985	6,434,138	6,434,138	--
Arkansas.....	3,632,901	3,602,195	3,602,195	--
California.....	35,060,462	34,764,127	34,764,127	--
Colorado.....	4,144,846	4,109,813	4,109,813	--
Connecticut.....	4,449,261	4,415,893	4,415,893	--
Delaware.....	1,779,331	1,767,150	1,767,150	--
Dist. of Columbia.....	1,779,331	1,767,150	1,767,150	--
Florida.....	26,208,251	25,986,733	25,986,733	--
Georgia.....	7,918,307	7,851,379	7,851,379	--
Hawaii.....	1,779,331	1,767,150	1,767,150	--
Idaho.....	1,779,331	1,767,150	1,767,150	--
Illinois.....	14,585,310	14,563,001	14,563,001	--
Indiana.....	7,307,851	7,246,084	7,246,084	--
Iowa.....	4,278,602	4,272,057	4,272,057	--
Kansas.....	3,447,188	3,441,915	3,441,915	--
Kentucky.....	4,974,669	4,932,622	4,932,622	--
Louisiana.....	5,080,467	5,037,526	5,037,526	--
Maine.....	1,779,331	1,767,150	1,767,150	--
Maryland.....	5,921,919	5,871,865	5,871,865	--
Massachusetts.....	8,243,243	8,230,634	8,230,634	--
Michigan.....	11,800,146	11,700,408	11,700,408	--
Minnesota.....	5,709,316	5,661,060	5,661,060	--
Mississippi.....	3,379,585	3,351,020	3,351,020	--
Missouri.....	7,272,351	7,210,884	7,210,884	--
Montana.....	1,779,331	1,767,150	1,767,150	--
Nebraska.....	2,304,485	2,300,960	2,300,960	--
Nevada.....	2,247,944	2,228,943	2,228,943	--
New Hampshire.....	1,779,331	1,767,150	1,767,150	--

**Administration on Aging
Grants to States for Home and Community-Based Supportive Services**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
New Jersey.....	10,673,627	10,583,411	10,583,411	--
New Mexico *.....	2,059,957	2,042,546	2,042,546	--
New York.....	24,384,444	24,347,147	24,347,147	--
North Carolina.....	9,555,618	9,474,852	9,474,852	--
North Dakota.....	1,779,331	1,767,150	1,767,150	--
Ohio.....	14,515,730	14,393,040	14,393,040	--
Oklahoma.....	4,428,893	4,391,459	4,391,459	--
Oregon.....	4,210,635	4,175,046	4,175,046	--
Pennsylvania.....	17,970,633	17,926,891	17,926,891	--
Rhode Island.....	1,779,331	1,767,150	1,767,150	--
South Carolina.....	4,816,292	4,775,584	4,775,584	--
South Dakota.....	1,779,331	1,767,150	1,767,150	--
Tennessee.....	6,968,624	6,909,724	6,909,724	--
Texas.....	20,509,181	20,335,834	20,335,834	--
Utah *.....	1,860,525	1,844,799	1,844,799	--
Vermont.....	1,779,331	1,767,150	1,767,150	--
Virginia.....	7,877,069	7,810,491	7,810,491	--
Washington.....	6,455,584	6,401,021	6,401,021	--
West Virginia.....	2,785,076	2,780,816	2,780,816	--
Wisconsin.....	6,709,373	6,652,664	6,652,664	--
Wyoming.....	1,779,331	1,767,150	1,767,150	--
American Samoa.....	474,281	473,556	473,556	--
Guam.....	889,666	883,575	883,575	--
Nothern Marianas.....	222,416	220,894	220,894	--
Puerto Rico.....	4,329,985	4,293,387	4,293,387	--
Virgin Islands.....	889,666	883,575	883,575	--
Undistributed **.....	1,114,745	3,570,000	3,570,000	--

* Funds distributions include transferring 1.83% from New Mexico and 0.4% from Utah to Arizona

** Funds held for statutory related requirements are reflected in the undistributed line.

**Administration on Aging
Grants to States for National Family Caregiver Support**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
Total Amount.....	\$141,492,000	\$141,500,000	\$141,500,000	--
Alabama.....	1,996,374	1,981,897	2,086,208	104,311
Alaska.....	644,212	639,540	673,200	33,660
Arizona *.....	2,337,036	2,320,088	2,442,198	122,110
Arkansas.....	1,303,240	1,293,789	1,361,883	68,094
California.....	12,657,601	12,565,808	13,227,167	661,359
Colorado.....	1,429,311	1,418,946	1,493,627	74,681
Connecticut.....	1,709,384	1,696,988	1,786,303	89,315
Delaware.....	644,212	639,540	673,200	33,660
Dist. of Columbia.....	644,212	639,540	673,200	33,660
Florida.....	10,083,438	10,010,315	10,537,174	526,859
Georgia.....	2,659,575	2,640,289	2,779,251	138,962
Hawaii.....	644,212	639,540	673,200	33,660
Idaho.....	644,212	639,540	673,200	33,660
Illinois.....	5,344,843	5,306,083	5,585,350	279,267
Indiana.....	2,661,771	2,642,469	2,781,546	139,077
Iowa.....	1,594,075	1,582,515	1,665,805	83,290
Kansas.....	1,290,151	1,280,796	1,346,206	67,410
Kentucky.....	1,745,716	1,733,057	1,824,270	91,213
Louisiana.....	1,788,389	1,775,420	1,868,864	93,444
Maine.....	646,191	641,505	675,268	33,763
Maryland.....	2,089,617	2,074,464	2,183,646	109,182
Massachusetts.....	3,120,206	3,097,579	3,260,609	163,030
Michigan.....	4,315,224	4,283,931	4,509,401	225,470
Minnesota.....	2,138,248	2,122,742	2,234,465	111,723
Mississippi.....	1,189,322	1,180,697	1,242,839	62,142
Missouri.....	2,666,197	2,646,862	2,786,171	139,309
Montana.....	644,212	639,540	673,200	33,660
Nebraska.....	837,679	831,605	875,373	43,768
Nevada.....	715,220	710,033	747,404	37,371
New Hampshire.....	644,212	639,540	673,200	33,660

**Administration on Aging
Grants to States for National Family Caregiver Support**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
New Jersey.....	3,974,716	3,945,892	4,153,571	207,679
New Mexico *.....	709,060	703,918	740,967	37,049
New York.....	8,680,794	8,617,843	9,071,414	453,571
North Carolina.....	3,326,460	3,302,337	3,476,145	173,808
North Dakota.....	644,212	639,540	673,200	33,660
Ohio.....	5,356,995	5,318,148	5,598,050	279,902
Oklahoma.....	1,586,096	1,574,594	1,657,467	82,873
Oregon.....	1,578,189	1,566,744	1,649,205	82,461
Pennsylvania.....	6,973,272	6,922,703	7,287,056	364,353
Rhode Island.....	644,212	639,540	673,200	33,660
South Carolina.....	1,646,884	1,634,941	1,720,991	86,050
South Dakota.....	644,212	639,540	673,200	33,660
Tennessee.....	2,417,677	2,400,144	2,526,468	126,324
Texas.....	7,087,631	7,036,233	7,406,561	370,328
Utah *.....	658,988	654,210	688,641	34,431
Vermont.....	644,212	639,540	673,200	33,660
Virginia.....	2,728,115	2,708,331	2,850,875	142,544
Washington.....	2,355,545	2,338,463	2,461,541	123,078
West Virginia.....	974,517	967,450	1,018,368	50,918
Wisconsin.....	2,522,840	2,504,545	2,636,363	131,818
Wyoming.....	644,212	639,540	673,200	33,660
American Samoa.....	80,526	79,943	84,150	4,207
Guam.....	322,106	319,770	336,600	16,830
Northern Marianas.....	80,526	79,943	84,150	4,207
Puerto Rico.....	1,409,945	1,399,720	1,473,389	73,669
Virgin Islands.....	322,106	319,770	336,600	16,830
Undistributed **.....	349,660	1,292,000	1,360,000	68,000
Indian Tribes ***.....	5,500,000	5,500,000	5,500,000	--
Innovation Grants ***.....	5,440,000	5,440,000	--	(5,440,000)
Activities of National Significance ***.....	1,360,000	1,360,000	--	(1,360,000)

* Funds distributions include transferring 1.83% from New Mexico and 0.4% from Utah to Arizona.

**Funds held for statutory related requirements are reflected in the undistributed line.

*** Funds reserved for Grants to Indian Tribes (for FY 2002-FY 2004), Innovation Grants and Activities of National Significance (for FY 2002-FY 2003) as mandated in Older Americans Act.

**Administration on Aging
Grants to States for Congregate Nutrition Services**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
Total Amount.....	\$390,000,000	\$390,000,000	\$390,000,000	--
Alabama.....	6,084,309	6,075,649	6,075,649	--
Alaska.....	1,943,897	1,930,500	1,930,500	--
Arizona *	6,616,894	6,516,525	6,516,525	--
Arkansas.....	4,174,474	4,168,532	4,168,532	--
California.....	35,750,030	35,207,166	35,207,166	--
Colorado.....	4,226,367	4,162,189	4,162,189	--
Connecticut.....	5,255,187	5,247,706	5,247,706	--
Delaware.....	1,943,897	1,930,500	1,930,500	--
Dist. of Columbia.....	1,943,897	1,930,500	1,930,500	--
Florida.....	26,723,715	26,317,912	26,317,912	--
Georgia.....	8,074,044	7,951,439	7,951,439	--
Hawaii.....	1,945,682	1,942,912	1,942,912	--
Idaho.....	1,943,897	1,933,101	1,933,101	--
Illinois.....	17,331,838	17,307,167	17,307,167	--
Indiana.....	8,127,101	8,115,532	8,115,532	--
Iowa.....	5,094,816	5,087,564	5,087,564	--
Kansas.....	4,100,620	4,094,783	4,094,783	--
Kentucky.....	5,584,848	5,576,899	5,576,899	--
Louisiana.....	5,660,793	5,652,735	5,652,735	--
Maine.....	2,001,384	1,998,535	1,998,535	--
Maryland.....	6,038,391	5,946,697	5,946,697	--
Massachusetts.....	9,805,895	9,791,936	9,791,936	--
Michigan.....	12,960,371	12,941,922	12,941,922	--
Minnesota.....	6,415,205	6,406,074	6,406,074	--
Mississippi.....	3,901,310	3,895,756	3,895,756	--
Missouri.....	8,489,234	8,477,150	8,477,150	--
Montana.....	1,943,897	1,930,500	1,930,500	--
Nebraska.....	2,745,978	2,742,069	2,742,069	--
Nevada.....	2,292,156	2,257,350	2,257,350	--
New Hampshire.....	1,943,897	1,934,983	1,934,983	--

Administration on Aging
Grants to States for Congregate Nutrition Services

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
New Jersey.....	12,222,431	12,205,033	12,205,033	--
New Mexico *	2,100,473	2,068,576	2,068,576	--
New York.....	29,039,750	28,998,414	28,998,414	--
North Carolina.....	9,743,557	9,595,601	9,595,601	--
North Dakota.....	1,943,897	1,930,500	1,930,500	--
Ohio.....	16,436,742	16,413,345	16,413,345	--
Oklahoma.....	5,094,049	5,086,798	5,086,798	--
Oregon.....	4,313,221	4,307,082	4,307,082	--
Pennsylvania.....	21,335,476	21,305,106	21,305,106	--
Rhode Island.....	1,955,294	1,952,511	1,952,511	--
South Carolina.....	4,911,019	4,836,445	4,836,445	--
South Dakota.....	1,943,897	1,930,500	1,930,500	--
Tennessee.....	7,172,864	7,162,654	7,162,654	--
Texas.....	20,912,556	20,594,997	20,594,997	--
Utah *	1,967,927	1,965,126	1,965,126	--
Vermont.....	1,943,897	1,930,500	1,930,500	--
Virginia.....	8,031,996	7,910,029	7,910,029	--
Washington.....	6,582,553	6,482,596	6,482,596	--
West Virginia.....	3,314,610	3,309,891	3,309,891	--
Wisconsin.....	7,606,874	7,596,046	7,596,046	--
Wyoming.....	1,943,897	1,930,500	1,930,500	--
American Samoa.....	596,401	595,552	595,552	--
Guam.....	971,949	965,250	965,250	--
Nothern Marianas.....	242,987	241,313	241,313	--
Puerto Rico.....	4,415,147	4,348,102	4,348,102	--
Virgin Islands.....	971,949	965,250	965,250	--
Undistributed **	1,220,563	3,900,000	3,900,000	--

* Funds distributions include transferring 1.83% from New Mexico and 0.4% from Utah to Arizona.

** Funds held for statutory related requirements are reflected in the undistributed line.

Administration on Aging
Grants to States for Home-Delivered Nutrition Services

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
Total Amount.....	\$176,500,000	\$178,500,000	\$178,500,000	--
Alabama.....	\$2,827,621	\$2,839,961	\$2,839,961	--
Alaska.....	\$879,738	\$883,575	\$883,575	--
Arizona *.....	\$3,223,773	\$3,237,842	\$3,237,842	--
Arkansas.....	\$1,804,850	\$1,812,727	\$1,812,727	--
California.....	\$17,418,283	\$17,494,303	\$17,494,303	--
Colorado.....	\$2,059,189	\$2,068,175	\$2,068,175	--
Connecticut.....	\$2,210,424	\$2,220,071	\$2,220,071	--
Delaware.....	\$879,738	\$883,575	\$883,575	--
Dist. of Columbia.....	\$879,738	\$883,575	\$883,575	--
Florida.....	\$13,020,443	\$13,077,267	\$13,077,267	--
Georgia.....	\$3,933,870	\$3,951,038	\$3,951,038	--
Hawaii.....	\$879,738	\$883,575	\$883,575	--
Idaho.....	\$879,738	\$883,575	\$883,575	--
Illinois.....	\$7,209,393	\$7,240,857	\$7,240,857	--
Indiana.....	\$3,630,592	\$3,646,436	\$3,646,436	--
Iowa.....	\$2,036,840	\$2,045,729	\$2,045,729	--
Kansas.....	\$1,670,529	\$1,677,819	\$1,677,819	--
Kentucky.....	\$2,471,450	\$2,482,236	\$2,482,236	--
Louisiana.....	\$2,524,012	\$2,535,027	\$2,535,027	--
Maine.....	\$879,738	\$883,575	\$883,575	--
Maryland.....	\$2,942,051	\$2,954,890	\$2,954,890	--
Massachusetts.....	\$4,027,479	\$4,045,056	\$4,045,056	--
Michigan.....	\$5,862,395	\$5,887,980	\$5,887,980	--
Minnesota.....	\$2,836,428	\$2,848,807	\$2,848,807	--
Mississippi.....	\$1,679,002	\$1,686,329	\$1,686,329	--
Missouri.....	\$3,612,955	\$3,628,723	\$3,628,723	--
Montana.....	\$879,738	\$883,575	\$883,575	--
Nebraska.....	\$1,087,705	\$1,092,452	\$1,092,452	--
Nevada.....	\$1,116,794	\$1,121,668	\$1,121,668	--
New Hampshire.....	\$879,738	\$883,575	\$883,575	--

**Administration on Aging
Grants to States for Home-Delivered Nutrition Services**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
New Jersey.....	\$5,302,733	\$5,325,875	\$5,325,875	--
New Mexico *.....	\$1,023,402	\$1,027,867	\$1,027,867	--
New York.....	\$11,768,890	\$11,820,251	\$11,820,251	--
North Carolina.....	\$4,747,298	\$4,768,016	\$4,768,016	--
North Dakota.....	\$879,738	\$883,575	\$883,575	--
Ohio.....	\$7,211,516	\$7,242,989	\$7,242,989	--
Oklahoma.....	\$2,200,305	\$2,209,908	\$2,209,908	--
Oregon.....	\$2,091,873	\$2,101,002	\$2,101,002	--
Pennsylvania.....	\$8,927,937	\$8,966,900	\$8,966,900	--
Rhode Island.....	\$879,738	\$883,575	\$883,575	--
South Carolina.....	\$2,392,768	\$2,403,210	\$2,403,210	--
South Dakota.....	\$879,738	\$883,575	\$883,575	--
Tennessee.....	\$3,462,061	\$3,477,171	\$3,477,171	--
Texas.....	\$10,189,105	\$10,233,572	\$10,233,572	--
Utah *.....	\$924,322	\$928,356	\$928,356	--
Vermont.....	\$879,738	\$883,575	\$883,575	--
Virginia.....	\$3,913,383	\$3,930,462	\$3,930,462	--
Washington.....	\$3,207,180	\$3,221,176	\$3,221,176	--
West Virginia.....	\$1,332,476	\$1,338,291	\$1,338,291	--
Wisconsin.....	\$3,333,263	\$3,347,810	\$3,347,810	--
Wyoming.....	\$879,738	\$883,575	\$883,575	--
American Samoa.....	\$135,561	\$135,698	\$135,698	--
Guam.....	\$439,869	\$441,788	\$441,788	--
Nothern Marianas.....	\$109,967	\$110,447	\$110,447	--
Puerto Rico.....	\$2,151,167	\$2,160,555	\$2,160,555	--
Virgin Islands.....	\$439,869	\$441,788	\$441,788	--
Undistributed **.....	\$552,383	1,785,000	1,785,000	--

* Funds distributions include transferring 1.83% from New Mexico and 0.4% from Utah to Arizona.

** Funds held for statutory related requirements are reflected in the undistributed line.

Administration on Aging
Grants to States for Nutrition Services Incentives

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
Total Amount *	\$149,670,000	\$149,670,000	\$149,670,000	--
Alabama.....	2,286,302	2,398,176	2,398,176	--
Alaska.....	358,411	376,835	376,835	--
Arizona.....	1,778,743	1,822,271	1,822,271	--
Arkansas.....	2,273,333	2,151,985	2,151,985	--
California.....	12,165,591	12,166,681	12,166,681	--
Colorado.....	1,238,114	1,236,855	1,236,855	--
Connecticut.....	1,897,060	1,914,682	1,914,682	--
Delaware.....	596,434	603,938	603,938	--
Dist. of Columbia.....	583,863	618,216	618,216	--
Florida.....	6,663,587	6,634,854	6,634,854	--
Georgia.....	2,611,267	2,554,101	2,554,101	--
Hawaii.....	504,674	509,847	509,847	--
Idaho.....	733,927	718,972	718,972	--
Illinois.....	6,154,016	6,227,332	6,227,332	--
Indiana.....	1,849,846	1,714,032	1,714,032	--
Iowa.....	2,484,547	2,275,389	2,275,389	--
Kansas.....	2,114,952	2,075,866	2,075,866	--
Kentucky.....	1,941,419	1,902,588	1,902,588	--
Louisiana.....	2,873,757	2,861,486	2,861,486	--
Maine.....	660,485	676,576	676,576	--
Maryland.....	1,960,267	1,931,358	1,931,358	--
Massachusetts.....	4,863,197	5,039,487	5,039,487	--
Michigan.....	7,242,888	7,088,877	7,088,877	--
Minnesota.....	2,883,620	2,868,660	2,868,660	--
Mississippi.....	2,005,634	1,995,549	1,995,549	--
Missouri.....	4,722,123	4,376,431	4,376,431	--
Montana.....	1,045,813	999,517	999,517	--
Nebraska.....	1,361,750	1,377,759	1,377,759	--
Nevada.....	705,129	761,651	761,651	--
New Hampshire.....	858,388	883,703	883,703	--

**Administration on Aging
Grants to States for Nutrition Services Incentives**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
New Jersey.....	3,176,670	3,312,007	3,312,007	--
New Mexico	1,642,425	1,666,518	1,666,518	--
New York.....	14,478,143	14,935,478	14,935,478	--
North Carolina.....	3,342,790	3,318,453	3,318,453	--
North Dakota.....	830,277	831,162	831,162	--
Ohio.....	5,224,487	5,087,938	5,087,938	--
Oklahoma.....	2,641,536	2,662,884	2,662,884	--
Oregon.....	1,631,898	1,491,176	1,491,176	--
Pennsylvania.....	7,041,028	6,902,626	6,902,626	--
Rhode Island.....	744,572	744,713	744,713	--
South Carolina.....	1,763,973	1,832,268	1,832,268	--
South Dakota.....	913,080	929,979	929,979	--
Tennessee.....	1,938,787	2,000,020	2,000,020	--
Texas.....	9,359,740	9,491,746	9,491,746	--
Utah	1,132,565	1,125,022	1,125,022	--
Vermont.....	540,144	571,019	571,019	--
Virginia.....	2,219,900	2,200,762	2,200,762	--
Washington.....	1,888,436	1,909,137	1,909,137	--
West Virginia.....	1,493,009	1,460,490	1,460,490	--
Wisconsin.....	3,206,995	3,192,681	3,192,681	--
Wyoming.....	722,636	737,655	737,655	--
American Samoa.....	-	-	-	--
Guam.....	243,457	248,318	248,318	--
Notern Marianas.....	58,266	59,296	59,296	--
Puerto Rico.....	2,070,050	2,212,413	2,212,413	--
Virgin Islands.....	--	95,677	95,677	--
Undistributed.....	--	--	--	--
Indian Tribes.....	1,946,000	1,886,888	1,886,888	--

* Funds distributed based on number of meals served in the prior year. If prior year's data is not available at the time the award is made, meal data from the year before will be used to calculate the first half of distribution, and adjusted when 2nd half of distribution is made.

**Administration on Aging
Grants to States for Preventive Health Services**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
Total Amount.....	\$21,123,000	\$21,562,000	\$21,562,000	--
Alabama.....	338,454	343,107	343,107	--
Alaska.....	105,284	106,732	106,732	--
Arizona *.....	385,871	391,177	391,177	--
Arkansas.....	216,033	219,003	219,003	--
California.....	2,084,898	2,113,557	2,113,557	--
Colorado.....	245,476	249,865	249,865	--
Connecticut.....	264,579	268,216	268,216	--
Delaware.....	105,284	106,732	106,732	--
Dist. of Columbia.....	105,284	106,732	106,732	--
Florida.....	1,558,493	1,579,918	1,579,918	--
Georgia.....	470,868	477,341	477,341	--
Hawaii.....	105,284	106,732	106,732	--
Idaho.....	105,284	106,732	106,732	--
Illinois.....	862,934	874,798	874,798	--
Indiana.....	434,567	440,541	440,541	--
Iowa.....	243,801	247,153	247,153	--
Kansas.....	199,955	202,704	202,704	--
Kentucky.....	295,822	299,889	299,889	--
Louisiana.....	302,114	306,267	306,267	--
Maine.....	105,284	106,732	106,732	--
Maryland.....	352,151	356,992	356,992	--
Massachusetts.....	482,072	488,700	488,700	--
Michigan.....	701,704	711,351	711,351	--
Minnesota.....	339,509	344,176	344,176	--
Mississippi.....	200,970	203,732	203,732	--
Missouri.....	432,456	438,401	438,401	--
Montana.....	105,284	106,732	106,732	--
Nebraska.....	130,194	131,984	131,984	--
Nevada.....	133,676	135,513	135,513	--
New Hampshire.....	105,284	106,732	106,732	--

1976

**Administration on Aging
Grants to States for Preventive Health Services**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
New Jersey.....	634,715	643,441	643,441	--
New Mexico *.....	122,497	124,181	124,181	--
New York.....	1,408,687	1,428,053	1,428,053	--
North Carolina.....	568,232	576,044	576,044	--
North Dakota.....	105,284	106,732	106,732	--
Ohio.....	863,188	875,055	875,055	--
Oklahoma.....	263,367	266,988	266,988	--
Oregon.....	250,388	253,831	253,831	--
Pennsylvania.....	1,068,637	1,083,328	1,083,328	--
Rhode Island.....	105,284	106,732	106,732	--
South Carolina.....	286,404	290,342	290,342	--
South Dakota.....	105,284	106,732	106,732	--
Tennessee.....	414,394	420,091	420,091	--
Texas.....	1,219,593	1,236,360	1,236,360	--
Utah *.....	110,638	112,159	112,159	--
Vermont.....	105,284	106,732	106,732	--
Virginia.....	468,416	474,855	474,855	--
Washington.....	383,886	389,164	389,164	--
West Virginia.....	159,492	161,684	161,684	--
Wisconsin.....	398,978	404,463	404,463	--
Wyoming.....	105,284	106,732	106,732	--
American Samoa.....	13,161	13,341	13,341	--
Guam.....	52,642	53,366	53,366	--
Nothern Marianas.....	13,161	13,341	13,341	--
Puerto Rico.....	257,486	261,026	261,026	--
Virgin Islands.....	52,642	53,366	53,366	--
Undistributed **.....	66,107	215,620	215,620	--

* Funds distributions include transferring 1.83% from New Mexico and 0.4% from Utah to Arizona.

**Funds held for statutory related requirements are reflected in the undistributed line.

Administration on Aging
Grants to States for Protection of Vulnerable Older Americans

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
Total Amount.....	\$17,681,000	\$17,681,000	\$17,681,000	--
Alabama.....	283,818	281,351	281,351	--
Alaska.....	88,289	87,521	87,521	--
Arizona *.....	323,580	320,769	320,769	--
Arkansas.....	181,159	179,584	179,584	--
California.....	1,748,331	1,733,130	1,733,130	--
Colorado.....	206,688	204,891	204,891	--
Connecticut.....	221,868	219,939	219,939	--
Delaware.....	88,289	87,521	87,521	--
Dist. of Columbia.....	88,289	87,521	87,521	--
Florida.....	1,306,905	1,295,544	1,295,544	--
Georgia.....	394,856	391,424	391,424	--
Hawaii.....	88,289	87,521	87,521	--
Idaho.....	88,289	87,521	87,521	--
Illinois.....	723,631	717,340	717,340	--
Indiana.....	364,414	361,247	361,247	--
Iowa.....	204,444	202,668	202,668	--
Kansas.....	167,676	166,219	166,219	--
Kentucky.....	248,068	245,911	245,911	--
Louisiana.....	253,343	251,142	251,142	--
Maine.....	88,289	87,521	87,521	--
Maryland.....	295,303	292,736	292,736	--
Massachusetts.....	404,251	400,738	400,738	--
Michigan.....	588,428	583,313	583,313	--
Minnesota.....	284,701	282,227	282,227	--
Mississippi.....	168,527	167,063	167,063	--
Missouri.....	362,644	359,492	359,492	--
Montane.....	88,289	87,521	87,521	--
Nebraska.....	109,176	108,228	108,228	--
Nevada.....	112,096	111,122	111,122	--
New Hampshire.....	88,289	87,521	87,521	--

**Administration on Aging
Grants to States for Protection of Vulnerable Older Americans**

	FY 2002 Actual	FY 2003 President's Budget	FY 2004 Estimate	FY 2004 +/- FY 2003
New Jersey.....	532,252	527,627	527,627	--
New Mexico *.....	102,722	101,828	101,828	--
New York.....	1,181,282	1,171,014	1,171,014	--
North Carolina.....	476,502	472,360	472,360	--
North Dakota.....	88,289	87,521	87,521	--
Ohio.....	723,844	717,552	717,552	--
Oklahoma.....	220,851	218,932	218,932	--
Oregon.....	209,968	208,143	208,143	--
Pennsylvania.....	896,126	888,337	888,337	--
Rhode Island.....	88,289	87,521	87,521	--
South Carolina.....	240,170	238,082	238,082	--
South Dakota.....	88,289	87,521	87,521	--
Tennessee.....	347,498	344,478	344,478	--
Texas.....	1,022,714	1,013,824	1,013,824	--
Utah *.....	92,778	91,971	91,971	--
Vermont.....	88,289	87,521	87,521	--
Virginia.....	392,799	389,385	389,385	--
Washington.....	321,915	319,117	319,117	--
West Virginia.....	133,745	132,583	132,583	--
Wisconsin.....	334,571	331,663	331,663	--
Wyoming.....	88,289	87,521	87,521	--
American Samoa.....	11,036	10,940	10,940	--
Guam.....	44,144	43,760	43,760	--
Northern Marianas.....	11,036	10,940	10,940	--
Puerto Rico.....	215,920	214,043	214,043	--
Virgin Islands.....	44,144	43,760	43,760	--
Undistributed **.....	23,319	176,810	176,810	--

* Funds distributions include transferring 1.83% from New Mexico and 0.4% from Utah to Arizona.

**Funds held for statutory related requirements are reflected in the undistributed line.

**Administration on Aging
Research Coordination Council Activities**

AoA conducts demonstration and evaluation activities that promote active aging and improve the delivery of long-term care services. AoA's participation in the HHS Research Coordination Council (RCC) has resulted in beneficial collaborations with other agencies and improved coordination of activities. For example:

- Through the RCC, AoA and ASPE discovered a mutual interest in the development of "Naturally Occurring Retirement Communities" (NORCs). AoA is funding five demonstration grants to develop and improve services in NORCs. These grants will demonstrate approaches to help seniors "age in place" by providing a package of home and community-based supportive services to them where they live. ASPE has agreed to fund an evaluation of the NORC grants. This collaboration will greatly enhance the quality and utility of the knowledge gained from the NORC demonstrations.
- Secretary Thompson asked AoA, in conjunction with ASPE, CMS, NIA, AHRQ, and other interested agencies, to develop a report summarizing the existing research evidence on Home and Community-Based Services (HCBS), and various models for integrating the health and social supports for older people, including what is known about the impact of such services and models on the health status and well-being of older people and their family caregivers, including the ability of older people to remain at home and in their communities. Since the RCC was already in place, and all the agencies noted above are members of the RCC Subgroup on Disability, Aging and Long-Term Care Workgroup, the agencies are using the RCC as the coordinating mechanism for carrying out this collaborative project.

AoA will continue to work with the RCC to identify opportunities for collaborations with other agencies and to explore new approaches for mobilizing the extensive resources available throughout HHS in order to close knowledge gaps and improve services to seniors and their families.

1980

**Administration on Aging
Research, Demonstration, and Evaluation Activities**
(Dollars in Thousands)

Research Priority:		FY 2004 Estimate
I.	Working Toward Independence.....	-
II.	Rallying the Armies of Compassion.....	-
III.	No Child Left Behind.....	-
IV.	Promoting Active Aging & Improving Long-Term Care.....	\$40,517
V.	Protecting & Empowering Specific Populations.....	-
VI.	Helping the Uninsured & Increasing Access to Health Insurance.....	-
VII.	Realizing the Possibilities of 21st Century Health Care.....	-
VIII.	Ensuring Our Homeland is Prepared to Respond to Health Emergencies.....	-
IX.	Understanding Health Differences & Disparities - Closing the Gaps.....	-
X.	Preventing Disease, Illness, and Injury.....	-
XI.	Agency-Specific Priorities.....	-
Total, Research, Demonstration, & Evaluation.....		\$40,517

Detail of Full-Time Equivalent Employment

	2002 <u>Actual</u>	2003 <u>Estimate</u>	2004 <u>Estimate</u>
Assistant Secretary for Aging.....	10	10	10
Center for Communication and Consumer Services.....	9	10	10
Center for Planning and Policy Development.....	9	10	10
Center for Wellness and Community-Based Services....	29	28	28
Center for Management.....	26	25	25
Regional Offices.....	37	37	37
Total FTE Usage, End of Year.....	120	120	120
HCFA-C-Funded FTE.....	(8)	(8)	(8)
Total Appropriation-Funded FTE.....	112	112	112

Average GS Grade

2000	13/5
2001	13/5
2002	13/4
2003	13/4
2004	13/4

Detail of Positions

	2002 <u>Actual</u>	2003 <u>Estimate</u>	2004 <u>Estimate</u>
Executive level I.....	--	--	--
Executive level II.....	--	--	--
Executive level III.....	--	--	--
Executive level IV.....	1	1	1
Executive level V.....	--	--	--
Subtotal.....	1	1	1
Total Executive Level Salaries.....	\$131,556	\$133,905	\$136,583
ES-6.....	1	1	1
ES-5.....	--	--	--
ES-4.....	--	--	--
ES-3.....	1	1	1
ES-2.....	1	1	1
ES-1.....	--	--	--
Subtotal.....	3	3	3
Total ES Salary.....	\$396,639	\$401,179	\$409,203
GS-15.....	17	19	19
GS-14.....	13	14	14
GS-13.....	48	50	50
GS-12.....	10	10	10
GS-11.....	5	5	5
GS-10.....	1	1	1
GS-9.....	11	11	11
GS-8.....	2	2	2
GS-7.....	4	4	4
GS-6.....	2	2	2
GS-5.....	1	1	1
Subtotal.....	114	119	119
Total GS Salary.....	\$8,303,619	\$8,735,677	\$9,069,041
Average ES Level.....	3	3	3
Average ES Salary.....	\$132,213	\$133,726	\$136,401
Average GS Grade.....	13/4	13/4	13/4
Average GS Salary.....	\$72,839	\$73,409	\$76,210

New Positions Requested

	2004		
	<u>Grade</u>	<u>Number</u>	<u>Annual Salary</u>
No New Positions Requested.....	—	—	—

1984

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION ON AGING

**FINAL ANNUAL
GPRA PERFORMANCE PLAN FOR
FISCAL YEAR 2004**

And

**REVISED ANNUAL PERFORMANCE PLAN FOR
FISCAL YEAR 2003**

And

**ANNUAL PERFORMANCE REPORT FOR FISCAL
YEAR 2002**

February 2003

Agency Contact: Frank Burns
Office of Evaluation, Administration on Aging
(202) 357-3516
Frank.Burns@aoa.gov

FROM THE ASSISTANT SECRETARY FOR AGING

The AoA Final Annual Performance Plan and Report for FY 2004 reflects my continued commitment to demonstrate and to improve the accountability of AoA and its partners for high quality, effective service to the elderly under the Older Americans Act.

- We help elderly individuals maintain their independence in the community by targeting services to the poor, disabled, minorities and rural residents. Over time we will work with States and communities to improve targeting to these vulnerable groups and measure our progress yearly.
- Integrated, coordinated services in the community offer the best opportunity for high quality services. We will continue to measure the rates of funding integration by States and local communities as an indicator of service integration.
- Elderly service consumers are in the best position to assess the impact of services on their well-being and independence. We will measure and improve consumer assessments of OAA services to the elderly and their caregivers over time.

Accountability through performance measurement is a high priority of mine, and I am proud of the following performance-measurement improvements that we have made since we submitted the FY 2003 plan last year. Specifically, we have:

- Placed the AoA component responsible for GPRA in the immediate office of the Assistant Secretary for Aging.
- Developed measurable long-term goals and performance measures which are consistent with and build on annual AoA goals.
- Reduced the number of measures in the AoA plan by 15%.
- Increased outcome measures to 75% of the measures in the AoA plan.
- Developed a FY 2004 budget that is based in large part on the analysis of performance results and program data from the States.
- Conducted six national performance outcome measures surveys for major AoA program services. Preliminary data are included in this plan and report.

Through his "One HHS" program management initiative, Secretary Tommy Thompson established consistent accountability among program officials in HHS, requiring our personal commitment to achieving the performance outcomes we have included in our GPRA performance plans. Through this plan, I am fully committed to effective program results for all older Americans.

Josefina G. Carbonell

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	3
• Agency Mission • Overview of the Plan and Performance Report	
I. OVERVIEW OF PERFORMANCE MEASUREMENT	7
• Report/Plan Road Map & Budget Linkage	
II. GOAL-BY-GOAL PERFORMANCE MEASUREMENT	10
2.1 COMMUNITY BASED SERVICES	10
• Program Description and Context • Program Performance Analysis	
2.2 VULNERABLE OLDER AMERICANS	29
• Program Description and Context • Program Performance Analysis	
2.3 SERVICES FOR NATIVE AMERICANS	32
• Program Description and Context • Program Performance Analysis	
2.4 AOA RESEARCH AND DEVELOPMENT	35
• Program Description and Context • Program Performance Analysis	
2.5 SENIOR MEDICARE PATROLS & TECHNICAL ASSISTANCE CENTERS	36
• Program Description and Context • Program Performance Analysis	
2.6 PROGRAM MANAGEMENT	40
• Program Description and Context • Program Performance Analysis	
III. APPENDICES TO PERFORMANCE PLAN	45
• Linkage to the HHS and Agency Strategic Plans • Changes and Improvements over the Previous Year • Approach to Performance Measurement • Data Verification, Validation and Other Data Issues • Performance Measurement Linkage with the Budget • Partnerships and Coordination	

EXECUTIVE SUMMARY

1. Agency Mission and Long-Term Goals

The Administration on Aging was established in 1965 through the enactment of the Older Americans Act (OAA), in response to the growing number of elders and their diverse needs. The OAA focuses especially on vulnerable elderly individuals who are at risk of losing their independence. AoA seeks continuously to improve the quality of life for all older Americans, primarily by assisting them to remain independent, actively engaged, and productive. AoA works closely with an aging network of State and local entities to plan, coordinate and develop home and community-based systems of services that meet the unique needs of older persons and their families.

The Older Americans Act, as reauthorized in 2000 for five years, enables AoA to be the Federal focal point for older persons, their many contributions and their concerns. AoA is Congressionally mandated to provide essential home and community-based programs across the country that help to keep America's rapidly growing older population healthy, secure and independent. The Act also charges AoA to serve as the effective and visible advocate for older individuals within the Department of Health and Human Services and with other departments and agencies of the Federal Government.

AoA is in the final stages of the development of a new strategic plan that will serve as the agency's road map to foster accountability for the elderly over the next five years. The mission of AoA is to promote the dignity and independence of older Americans and to help society prepare for an aging population. The Assistant Secretary for Aging is defining AoA priorities that will help the agency achieve the following among the measurable strategic goals, which have already been shared with OMB staff in AoA's recent PART program assessment.

1. *Target Older Americans Act services to vulnerable elderly individuals.*

Measure: By FY 2007, AoA will increase the percentage of Older Americans Act clients who live in rural areas to 38% of all clients.

It is those who are frail, poor, and lack adequate access to care who are at the greatest risk of institutionalization and loss of independence. The Department of Health and Human Services has established initiatives to foster services to those in rural areas because limited access to care increases the vulnerability of those in rural areas who need care. AoA's measure for this goal recognizes the importance of the HHS initiative and the increased risk the rural elderly face because of limits in service

access that can result from long distances and limited communal service resources.

2. *Integrate Federal, State and Local Services for the elderly.*

Measure: By FY 2007, the rate of non-AoA funding for Older Americans Services will increase by 20%.

In the face of a rising elderly population and scarce service resources, the integration and coordination of funding and service provision for elderly who need care is an essential element of program quality. The Department of Health and Human Services is committed to the integration of health and social services on behalf of individuals in communities. This goal and measure supports Departmental initiatives and fosters continued improvement by the State and local entities which currently generate approximately \$2 from other sources for every dollar AoA provides.

3. *Increase the Impact of Older Americans Act Programs on the Elderly*

Measure: By FY 2007, increase the percentage of elderly individuals served by Older Americans Act programs to 17% of the elderly population.

The community-based services of the Older Americans Act programs, provided significantly by family members and volunteers, are a cost-effective alternative to institutionalization. Serving a greater percentage of the elderly population and their caregivers is a fundamental measure of impact and outreach that encourages communities to seek out the vulnerable who are at risk of losing their independence.

AoA also participates in the development of the strategic goals and objectives of the Department of Health and Human Services (HHS) each year. AoA program activities and strategies will continue to support the achievement of HHS goals and objectives, and AoA program performance measurement efforts will support HHS efforts to assess the progress of the Department in achieving the goals and objectives of the HHS Strategic Plan. The detailed roadmap of linkages of AoA goals and activities with the HHS Strategic Plan are presented in Appendix 1 of this plan.

4. *Organization, Programs, Operations, Strategies and Resources*

The Administration on Aging provides leadership, coordination and support to the aging network on behalf of older Americans. AoA works to heighten awareness among other Federal agencies, organizations, groups, and the public about the

valuable contributions that older Americans make to the Nation and alerts them to the needs of vulnerable older people.

In FY 2002, the Assistant Secretary for Aging reorganized the agency to focus on consumers. The four major operating components of AoA are now:

- The Center for Planning and Policy Development
- The Center for Communication and Consumer Services
- The Center for Wellness and Community-Based Services, and
- The Center for Management

This new structure streamlines the organization, consolidates and elevates AoA's external communications functions, centralizes and strengthens its analytical and policy development activities, and focuses AoA's programmatic efforts on those areas of greatest importance to older Americans.

State, tribal and area agencies on aging ensure coordination and enhancement of services that help vulnerable older persons to remain in their own homes. Fifty-six State agencies on aging are allocated funds for support services based on a formula that reflects the number of older residents in their State. Funds are used to plan, develop, and coordinate in-home and community-based service systems in their States. A total of 655 area agencies on aging (AAAs) receive OAA funds from the State. Area agencies contract with about 29,000 public or private providers in local areas. AoA awards funds directly to 241 Indian tribal organizations and 2 organizations serving Native Hawaiian elders. These organizations are direct providers of services to older Native Americans living on or near Indian reservations, historical Indian lands, Alaska Native villages and Native Hawaiian communities. The State, local and tribal entities to which AoA awards grants under the authority of the Older Americans Act, and the service providers they support, comprise the aging network.

The aging network is responsive to the diverse needs of older Americans. Meals are served in congregate settings such as senior centers, mostly to people who are poor and socially isolated. Many older people with mild functional impairments also need such supportive services as transportation. For older people with more severe limitations, the aging network provides home and community-based long-term care services through a system that it began to develop in the 1970's. In communities throughout the nation, the home and community-based service systems led by the aging network provide a preferred alternative to nursing home care, enabling people to live as independently as possible for as long as possible.

• Overview of Plan and Performance Report

With the Government Performance and Results Act (GPRA), the Congress established a management tool that compels Federal agencies and programs to focus on results. For AoA, GPRA is an opportunity to document results

produced through the programs the agency administers under the authority of the Older Americans Act (OAA).

The final performance plan for FY 2004 also reflects technical improvements sought by the Department of Health and Human Services and the Office of Management and Budget (OMB). AoA has reduced the number of goals/measures in the plan, focused on outcomes, and used performance data to support the agency's budget justification for FY 2004. This FY 2004 plan contains 39 performance measures (including 6 final outcome placeholder measures), which is 7 measures or 15% fewer than in FY 2003. Approximately 75% (29) of these measures are intermediate or final outcome measures. Throughout the plan, we identify the performance results that have contributed to AoA's FY 2004 budget justification. AoA contacts responsible for the preparation of this plan are Frank Burns (202-357-3516) and Saadia Greenberg (202-357-3554).

I. OVERVIEW OF PERFORMANCE MEASUREMENT

- Report/Plan Road Map and Budget Linkage

The following performance report summary updates that presented in the final performance plan for FY 2003. The most significant advancement in performance reporting for this report is that it includes final FY 2001 data earlier than originally anticipated. As indicated above with the presentation of AoA measurable strategic goals, the detailed roadmap of linkages of AoA goals and activities with the HHS Strategic Plan are presented in Appendix 1 of this plan. The following chart illustrates the status of AoA reporting of performance measures included in its GPRA performance plans.

	<u>Measures in Plan</u>	<u>Results Reported</u>	<u>Results Met</u>	<u>Unreported</u>
1999	18	18	14	0
2000	18	18	13	0
2001	23	23	17	0
2002	32*	5	5	27
2003	46*	NA	NA	NA
2004	39*	NA	NA	NA

* Includes placeholders for six final outcome measures for which data is not yet available.

The data for the performance measures (FY 1997 to 2001) identified throughout this plan present a story of performance indicating that the network produces the results intended by the Older Americans Act (OAA). The network:

- successfully targets services to vulnerable elderly individuals, including the poor, minorities, and individuals from rural areas;
- leverages funding from other sources in amounts that were almost double the funding provided by AoA;
- leverages funding for critical in-home and adult-day-care services in amounts almost triple the funding provided by AoA;
- fosters extensive participation of volunteers, even in the local entities that help to administer the OAA programs; and
- works systematically to improve service coordination, as demonstrated particularly by the high percentage of senior centers, which are "focal points" for community services.

Budget Linkage

AoA has strongly linked the initial AoA GPRA Plan for FY 2004 and the FY 2004 budget submission by using GPRA and other program data to support its budget priorities for FY 2004. The data presented in this plan and report form the basis for AoA's budget focus on maintaining home and community-based services and supporting family caregivers. This is clearly demonstrated throughout the budget justification.

The categories of measures and the associated budget priorities they support include:

- The intermediate outcome targeting measures (which document the effectiveness of the aging network in targeting services to vulnerable individuals) **support the AoA priorities to maintain home and community-based services and improve the integration of access to services in the aging network. States and communities target services to vulnerable elderly individuals at significantly higher levels than the representation of these populations among the total elderly population.**
- The intermediate outcome system measures (which show the leveraging of funds and illustrate levels of integration) **support AoA efforts to maintain program funding and its pursuit of improvements in the integration of home and community-based services across the network. Overall, States leverage funds from other sources at rates that double the AoA funding, and those rates rose in FY 2001.**
- The service output measures (which document declines in critical transportation services and information and assistance) **support AoA's priority to maintain funding levels and improve integration of services at the community level so as to identify additional sources of funding for these critical home and community-based services. Although projected targets for tracked services have not been met in all cases, most service levels continue to rise.**
- The Medicare Senior Patrols Program measures (which document the use of seniors to support efforts to reduce Medicare fraud) **support continued funding of efforts to train elders for this effort.**

For GPRA presentation purposes, the AoA programs, by budget line item, have been grouped into six GPRA Programs:

- **Community-Based Services** contains budget line items:
 - Home and Community-based Supportive Services (HCBS)
 - Congregate Meals
 - Home-Delivered Meals
 - Preventive Health Services
 - National Family Caregiver Support Program (NFCSP)

- **Vulnerable Older Americans** contains budget line items:
 - Ombudsman Services
 - Prevention of Elder Abuse
- **Native American Services** contains budget line item:
 - Grants to Indian Tribes
- **Research and Development** contains budget line items:
 - Program Innovation Projects
 - Alzheimer's Disease Demonstration Grants to States
 - Aging Network Support Activities
- **Senior Medicare Patrols** contains budget line item:
 - Senior Medicare Patrols (HCFAC)
- **Program Management** contains budget line item:
 - Program Administration

II. GOAL-BY-GOAL PERFORMANCE MEASUREMENT

2.1 COMMUNITY-BASED SERVICES

Program Description and Context

(numbers in thousands)	FY 2001 Enacted	FY 2002 Enacted	FY 2003 President's Budget	FY 2004 HHS Budget
Community Based Services	\$1,151,462	\$1,235,766	\$1,238,232	\$1,238,232

The Community-Based Services program comprises AoA's budget line items for programs administered by State and community agencies, with the exception of the Protection of Vulnerable Older Americans line, which we have elected to show separately for GPRA purposes. State agencies on aging are allocated funds for state and community programs based on formulas that reflect the number of older residents in their state. AoA, other Federal, and outside source funds are used by state and area agencies on aging and service providers to coordinate and to provide services for elderly individuals.

The Community-Based Services program covers the majority of the resources, services and activities of AoA and the aging network. The program provides "access" services, such as information and assistance, outreach, and transportation. The program covers "community" services, which include congregate meals, senior-center activities, adult day care, pension counseling, and health promotion and fitness programs. The program provides "in-home" services, including home-delivered meals, chores, home maintenance assistance, home-health, and personal care. The program includes "caregiver" support, such as respite services and information and assistance to caregivers for the coordination of health and social services.

Program Performance Analysis

The FY 2004 performance plan includes the following types of performance measures for community-based programs:

- **Intermediate outcome targeting measures.** Does the network target services to vulnerable elderly individuals and have there been improvements in the delivery of these services?
- **Intermediate outcome system measures.** What do the State and local components of the network contribute to the elderly in the way of resources, coordination, and emphasis on the most vulnerable?
- **Service output measures.** What level of services will the network provide to elderly individuals each year for meals, transportation, etc.?

- **End outcome measures.** From the perspective of elderly consumers and their caregivers, what results are AoA and the network producing for the elderly?

Performance Measures Table—Intermediate Outcome Targeting Measures (Part 1)

Performance Goals	Targets	Actual Performance	Notes
INTERMEDIATE OUTCOME TARGETING MEASURES:			
<u>Poverty</u>			
A significant percentage of OAA Title III service recipients are poor.	FY 04: 32% FY 03: 32% FY 02: 25% FY 01: 25% FY 00: (New in 01)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 29.3% FY 00: 30.3% FY 99: 31.7% FY 98: 36.2% FY 97: 39.1%	6
Norm: Percent of U.S. elderly population who are poor: 2000: 10.2%			
Increase participation by the poor in States -- <i>developmental</i>	FY 04: 7 States FY 03: 5 States FY 02: (New in 03)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 02/03	
<u>Rural Residence</u>			
A significant percentage of OAA Title III service recipients live in rural areas.	FY 04: 34% FY 03: 34% FY 02: 25% FY 01: 25% FY 00: (New in 01)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 30.4% FY 00: 32.9% FY 99: 33.6% FY 98: 33.5% FY 97: 32.6%	6
Norm: Percent of U.S. elderly population who live in rural areas: 2000: 23%			
Increase rural participation in States -- <i>developmental</i>	FY 04: 7 States FY 03: 5 States FY 02: (New in 03)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 02/03	

Performance Measures Table—Intermediate Outcome Targeting Measures (Part 2)

Performance Goals	Targets	Actual Performance	Notes
INTERMEDIATE OUTCOME TARGETING MEASURES			
<u>Minorities</u>			
A significant percentage of OAA Title III service recipients are minorities.	FY 04: 20% FY 03: 19% FY 02: 17% FY 01: 17% FY 00: (New in 01)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 18.8% FY 00: 19.1% FY 99: 19.3% FY 98: 19.6% FY 97: 21.8%	6
Norm: Percent of U.S. elderly population who are minorities: 2000: 16.4%			
<u>Caregivers</u>			
Increase the ratio of family caregivers to registered clients. -- <i>developmental</i>	FY 04: 1.5 to 10 FY 03: 1.0 to 10 FY 02: (New in 03)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: (baseline: 06/03)	6
<u>Disability</u>			
Increase participation by disabled elderly in States -- <i>developmental</i>	FY 04: 7 States FY 03: 5 States FY 02: (New in 03)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04	6
<u>Services to Senior Elders (75 + years)</u>			
Increase participation by senior elders in States -- <i>developmental</i>	FY 04: 7 States FY 03: 5 States FY 02: (New in 03)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04	

(Note: The targeting measures are presented in two tables for ease of presentation.)

Performance Measures Analysis—Intermediate Outcome Targeting Measures

The OAA seeks to ensure and to support the well-being of elderly Americans, particularly those who are most vulnerable, including the poor, minorities, disabled, and the elderly in rural areas. It is not enough that the network provide

services; the network must reach out to and serve the most vulnerable among the elderly.

AoA has identified a set of targeting measures to track the effectiveness of the network in meeting the intent of the OAA to serve vulnerable elderly individuals, and to target measurable improvements where appropriate. AoA and the network are also focusing on targeting services to caregivers to ensure the successful implementation of the new program.

- If AoA is to demonstrate that the network is targeting services to vulnerable individuals, then ***data should show that the percentage of clients who are poor, disabled, minorities and those in rural areas, is significantly higher than the percentage of all elderly persons in the total population who fit these characteristics.***

Results for Intermediate Outcome Targeting Measures

For AoA targeting measures, the tables above indicate ***that the aging network effectively targets services to the vulnerable elderly individuals in the Nation.***

- **Poverty Targeting Measures:** Whereas 10% of all elderly over 60 years old were poor, 30% or more of aging network clients were poor for all years reported.
- **Rural Targeting Measure:** For all years reported, nearly one-third of OAA program participants in FY 1999 lived in rural areas, compared to less than one-quarter for the total population age 60 and above.
- **Minority Targeting Measure:** The percent of OAA clients who were minorities (19%) remains higher than the total percent of all elderly minority individuals (16%).
- **Disability Targeting Measure:** Disability data for 42 States show that a very high percentage of clients receiving home delivered meals have limitations in Activities of Daily Living (ADL's) and in Instrumental Activities of Daily Living (IADL's). **This data indicates that states, as a whole, are successfully targeting services to disabled elderly individuals.**
- **Senior Elders Targeting Measure:** Data on age categories for 42 states show that a high percentage of clients (over 60%) receiving registered services are aged seventy-five and above. **This data indicates that states as a whole are successfully targeting registered services to elderly individuals aged seventy-five and above.**

- **Caregiver Targeting Measure:** The caregiver program was implemented in FY 2001. The Network has no results data to report thus far.

AoA is concerned about the trends represented in the tables above indicating that the percentage of vulnerable target populations receiving services appears to be declining. The following addresses AoA's approach to monitoring this activity and ensuring that the current high level of performance is maintained.

Goals and Targets

Performance targets for FY 2004 are based on the past and current performance of the network as reflected in the tables above. To ensure the continued successful performance of the network in targeting services to vulnerable elderly individuals, **AoA seeks to maintain performance at or near the levels established over the last few years.** The national targets for FY 2004 for serving poor and rural clients have been maintained at the 2003 level to reflect that intention. The national target for serving minority clients has been increased.

AoA's intermediate outcome targeting measures are a significant factor in the agency's priorities for the FY 2004 budget. Even though the network effectively targets services to vulnerable individuals overall, the percentage who are vulnerable (poor, rural and minority) appears to be declining. In FY 2004, AoA will maintain its support of community-based services and foster improved integration of home and community-based services to better serve vulnerable populations. AoA is already conducting analysis of the current characteristics of systems across the nation, including the assessment of best practices, which will speak to many of the factors that influence the effectiveness of State and local entities in targeting services to those who need them most.

In its commitment to continuously improve program performance where it is needed, AoA is proposing to improve performance for primary service States that do not perform at the national average for targeting services. ***AoA proposes to improve performance in five States in FY 2003 and seven States in FY 2004 for which client service ratios are below national or multi-State service ratios for poverty, rural residence, disability status, and service to senior elders.***

AoA's targeting measure for the National Family Caregiver Support Program is the ratio of caregivers to registered clients. To demonstrate that the program is having an impact, this ratio should increase over time. The initial commitment for the caregiver program is to serve 250,000 family caregivers. This equates to a ratio for the 3 million registered clients of less than 1 to 10. AoA continues in the FY 2004 budget to maintain resources for the caregiver program, because it is likely that a very many of the network's 3 million registered clients are supported by a family caregiver, who helps the elderly client maintain their independence and who could benefit from caregiver services from the aging network.

Performance Measures Summary Table— Intermediate Outcome System Measures (Part 1)

Performance Goals	Targets	Actual Performance	Notes
INTERMEDIATE OUTCOME SYSTEM MEASURES:			
<u>Leverage Funding</u>			
Maintain a high ratio of Leveraged funds to AoA funds.	FY 04: \$2.20 to \$1.00 FY 03: \$1.90 to \$1.00 FY 02: \$1.50 to \$1.00 FY 01: \$1.50 to \$1.00 FY 00: (New in 01)	FY04: 02/06 FY03: 02/05 FY 02: 02/04 FY 01: \$2.10 to \$1.00 FY 00: \$1.90 to \$1.00 FY 99: \$1.90 to \$1.00 FY 98: \$1.90 to \$1.00 FY 97: \$1.80 to \$1.00	6
Increase leveraged funding ratios for States -- <i>developmental</i>	FY 04: 5 States FY 03: 5 States FY 02: (New in 03)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04	
A high percentage of funding for the following services will come from leveraged funds: ■ Personal Care ■ Home-Delivered Meals ■ Adult Day Care	FY 04: 76% FY 03: 74% FY 02: 70% FY 01: 70% FY 00 (New in 01)	FY04: 02/06 FY03: 02/05 FY 02: 02/04 FY 01: 74.5% FY 00: 74% FY 99: 75% FY 98: 75% FY 97: 74%	
<u>Program Income</u>			
Maintain a high ratio of network program income to AoA funding.	FY 04: (Discontinued) FY 03: \$.35 to \$1.00 FY 02: \$.30 to \$1.00 FY 01: \$.30 to \$1.00 (New in 01)	FY04: 02/06 FY03: 02/05 FY 02: 02/04 FY 01: \$.37 to \$1.00 FY 00: \$.35 to \$1.00 FY 99: \$.35 to \$1.00 FY 98: \$.37 to \$1.00 FY 97: \$.37 to \$1.00	6
Increase program income ratios for States)— <i>developmental</i>	FY 04: 5 States FY 03: 5 States FY 02: (New in 03)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04	

**Performance Measures Summary Table—Intermediate Outcome System
Measures (Part 2)**

Performance Goals	Targets	Actual Performance	Notes
INTERMEDIATE OUTCOME SYSTEM MEASURES			
<u>Senior Center Focal Points</u>			
Maintain high percentage of senior centers that are community focal points.	FY 04: 62% FY 03: 60% FY 02: 50% FY 01: 50% FY 00 (New in 01)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 58.1% FY 00: 61.2% FY 99: 59.5% FY 98: 58.8% FY 97: 57.9%	6
<u>Area Agency Volunteers</u>			
Maintain high percentage of volunteer staff among area agencies on aging. (discontinued)	FY 04: (Discontinued) FY 03: 46% FY 02: 40% FY 01: 40% FY 00: (New in 01)	FY 03: 02/05 FY 02: 02/04 FY 01: 41.8% FY 00: 44.1% FY 99: 45.9% FY 98: 43.8% FY 97: 50.7%	6
Increase volunteer staff participation for State Agencies	FY 04: 5 States FY 03: Number of States (new in 04)	FY 04: 02/06 FY 03: 02/05	6
<u>Caregiver</u>			
Increase the number of State agencies on aging that provide caregiver services in all five service categories -- developmental	FY 04: 10 States FY 03: 10 States FY 02: (New in 03)	FY 04: FY 03: TBD FY 02: 02/04 FY 01: Baseline 06/03	6

Performance Measures Analysis— Intermediate Outcome System Measures

Intermediate Outcome System measures data should show that: (1) *there is a significant contribution above and beyond funding provided by AoA*; (2) *there is a strong degree of coordination of services provided through the network*; and (3) *the network is community oriented and makes use of community resources.*

Results for Intermediate Outcome Systems Measures

The data reported above for AoA's intermediate outcome system measures demonstrate the following:

1. *The funds "leveraged" by the aging network are significant in total, almost doubling AoA funds for all years reported.*
 2. *The leveraged funds substantially exceed the funding provided by AoA for home and community services to the elderly, particularly the disabled who required in-home services and adult day care.*
 3. *The network does not rely solely on funds provided by other sources, but every year generates a significant amount of revenue, which is put back into the program for services.*
 4. *The network is characterized by a strong community orientation, in which senior centers are not only places where elderly individuals receive services, but are places where services for the elderly are organized and coordinated.*
 5. *The network is committed to local solutions and resources in support of the elderly, as reflected in data that show that almost 40% of area agency staff are volunteers.*
- **Leveraged Funding Measures:** For all years reported, FY 1997 through FY 2001,
- funds leveraged by State and local agencies exceeded funds provided by AoA by almost 100%, and for FY 2001 exceeded that level; and
 - approximately three-quarters of the funding that supported personal care, home-delivered meals, and adult day care combined, came from sources other than AoA.
- **Program Income Measure:** Data for all five fiscal years indicate that revenue generated by the aging network (e.g., voluntary contributions for meals) is a significant funding source, representing approximately one-third of the amount provided by AoA each year. In FY 2001, network generated program income rose to 37% of AoA funds.

- **Senior Center Focal Point Measure:** Each year, over half of all senior centers participating in the program were community-service "focal points."
- **Area Agency Volunteer Measure:** The percentage of the staff of area agencies on aging that is made up of volunteers was between 40 and 50 percent in FYs 1997 through 2001.
- **Caregiver Measure:** For the National Family Caregiver Support Program, our initial objective for the "system" is to develop a well-rounded program that serves the various needs of caregivers as envisioned by the OAA. The developmental measure addresses the extent to which State agencies develop comprehensive caregiver programs that provide the variety of services required by the OAA.

Goals and Targets

Performance targets for FY 2004 are based on the past and current performance of the network as reflected in the tables above. Because of the outstanding overall performance of the network for all of the defined intermediate outcome systems measures, AoA seeks to maintain performance at or near the levels established as national performance targets over the last few years. AoA does not believe that the FY 2001 declines for the focal point and volunteer staff measures are either significant or permanent. As a result, the national targets for FY 2004 for **leveraging funds**, **program income**, and **focal points** have been maintained at high FY 2003 levels.

Consistent with this intention, AoA is committed to continuously improve program performance where it is needed. ***AoA proposes in FY 2003 and 2004 to improve performance in five States for which client service ratios are below national or multi-State service ratios for leveraged funding and program income. In FY 2004, AoA will improve volunteer staff ratios in 5 States where the ratios are below the national average.***

AoA's intermediate outcome system measures are also a significant factor in the agency's priorities for the FY 2004 budget. Even though the network overall effectively leverages funds and attracts volunteers on behalf of vulnerable elderly individuals, there are significant variations among States. AoA will maintain funding at current levels, and is conducting analyses which will identify best practices associated with the integration of home and community-based services. This analysis will speak to many of the factors that influence the effectiveness of State and local entities in leveraging funds and attracting volunteers for those who need services.

In the interests of reducing the number of performance measures in the GPRA plan, AoA will discontinue the national program income measure and the national area agency volunteer staffing measures beginning in FY 2004.

Performance Measures Summary Table—Service Measures (Part 1)

Performance Goals	Targets	Actual Performance	Notes
SERVICE OUTPUT MEASURES	{numbers in millions}	{numbers in millions}	
<u>Nutrition</u>			
Increase the number of home-delivered meals provided.	FY 04: 183.0 FY 03: 183.0 FY 02: 183.0 FY 01: 176.0 FY 00: 155.0 FY 99: 119.0	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 143.8 FY 00: 143.4 ✓ FY 99: 134.6 ✓ FY 98: 129.7 FY 97: 123.4 FY 96: 119.1 FY 95: 119.0	1
Maintain the number of congregate meals provided.	FY 04: 115.2 FY 03: 115.2 FY 02: 115.2 FY 01: 115.2 FY 00: 113.1 FY 99: 123.4	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 112.2 FY 00: 115.8 ✓ FY 99: 112.8 ✓ FY 98: 114.1 FY 97: 113.1 FY 96: 118.6 FY 95: 123.4	1
<u>Transportation</u>			
Maintain the number of units of service provided.	FY 04: 50.7 FY 03: 50.7 FY 02: 50.7 FY 01: 50.7 FY 00: 46.6 FY 99: 39.5	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 39.4 FY 00: 42.8 ✓ FY 99: 45.8 ✓ FY 98: 45.7 FY 97: 46.6 FY 96: 36.9 FY 95: 39.5	6

Performance Measures Summary Table—Service Measures (Part 2)

Performance Goals	Targets	Actual Performance	Notes
SERVICE OUTPUT MEASURES	(numbers in millions)	(numbers in millions)	
<u>Information and Assistance</u>			
Maintain the number of units of service provided.	FY 04: 15.2 FY 03: 15.2 FY 02: 15.2 FY 01: 15.2 FY 00: 14.0 FY 99: 12.5	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 13.1 FY 00: 13.4 ✓ FY 99: 12.2 ✓ FY 98: 13.1 FY 97: 14.0 FY 96: 13.7 FY 95: 12.5 Contacts	6
<u>Caregiver Services</u>			
Increase the number of caregivers served. – developmental	FY 04: 300,000 FY 03: 250,000 FY 02: (New in 03)	FY 04: 02/05 FY 03: 02/04 FY 02: 275,000 (preliminary baseline)	6

Service Output Measures

The measures in this section of the plan are output measures that provide a basis for tracking the level of services that AoA and the other components of the network provide. Rather than encumber the plan with extensive counts for a variety of services, AoA will continue to report on major service categories identified in the table above, with the view that they are representative of AoA funded activity.

In FY 2003, AoA added a developmental measure for the National Family Caregiver Support Program, which is consistent with the expectations of the Congress for the new program. Primarily, it is the objective of the program to reach out to caregivers. Thus, at least initially, it is more relevant for AoA to identify the number of individuals served than the units of service provided. In addition, AoA and the network must identify consistent definitions of service units prior to establishing measures of such units.

Service output data should show that over time performance outputs are consistent with the level of resources provided by AoA and the anticipated level of resources provided by other network sources through the States.

Results for Service Output Measures

The data for FY 2001 and for previous years reflect that AoA and the Network are providing a level of service that is consistent with funding provided and with changes in service costs. For example, the number of home-delivered meals provided continues to rise, and in FY 2001 was higher than for any of the previous years presented in the table above. However, the increases for home-delivered meals and other services were not as great as AoA had projected, most likely due to unusual and unanticipated cost increases (eg.: fuel) As a result, the data for FY 2001 indicate that AoA did not meet service performance targets for any of the four output measures included in the FY 2001 annual performance plan.

- **Home Delivered Meals Output Measures:** *The data reflects a modest increase in the number of home-delivered meals provided in FY 2001, and the highest number of meals provided in the seven years represented in the table above.* We did not meet the higher targeted result, which we believe reflects two factors: 1) the difficulty of accurately targeting the number of meals that will be served in a given fiscal year, and 2) cost increases (particularly fuel costs) associated with delivering the meals. Because this is the second year in which actual performance for this output measure is below projected targets, AoA will conduct a more detailed analysis of this phenomenon over the next year.
- **Congregate Meals Output Measure:** FY 2001 data indicates that the network did not meet its target for congregate meals, and that the number of congregate meals served declined to approximately the FY 1999 levels.
- **Transportation Output Measure:** The level of output performance for transportation service did not meet the FY 2001 target and declined for the second consecutive year. Although AoA overstated the FY 2000 and 2001 targets when it based them on data for FY 1997, we are concerned about the continued fall in transportation service units. Further analysis of program data indicated that the average cost for a trip continues to rise substantially, from approximately \$3.50 in FY 1999 to \$4.00 in FY 2000 and to \$4.67 in FY 2001, suggesting that rising fuel prices contributed to the phenomenon.
- **Information and Assistance Output Measures:** The level of output performance for information and assistance also did not meet, the FY 2001 target. However, because service output for information and assistance has been stable over the last five years, consistent with stable funding, we do not believe that the level reported reflects a significant problem for the Network.
- **Caregiver Output Measure:** The caregiver program was implemented in FY 2001. Preliminary data provided to AoA by State agencies indicates

that the Network has exceeded the legislative target of serving 250,000 caregivers in FY 2002. Preliminary estimates indicate the States have provided direct service to a minimum of 275,000 caregivers in FY 2002. When program data on caregivers served are finalized, AoA will establish appropriate targets for caregiver services in the FY 2005 GPRA plan.

Goals and Targets for Service Output Measures

Performance targets for FY 2004 are based on the past and current performance of the Network. Even though AoA's performance for FY 2001 and FY2000 was significantly below performance targets, AoA will continue to maintain at a constant level the performance targets for its service output measures. We will, however, conduct a more concentrated analysis of the factors that are apparently affecting the output totals the States are reporting. It is clear from leveraged funding data that other funding sources are matching the AoA investment in these services. However, increasing costs seem to be affecting the level of output the States can produce with the added investment.

Performance Measures Summary Table—Client and Program Outcome Measures

Performance Goals	Targets	Actual Performance	Notes
CLIENT AND PROGRAM OUTCOME MEASURES		(NOTE: See analysis of preliminary data in presentation below.)	
<u>Nutrition</u>			
The average nutritional risk score for established OAA clients will be lower than the average score for new clients. -- <i>developmental</i>	FY 04: FY 03: FY 02: (new in 03)	FY 04: FY 03: FY 02:	1
A high percentage of new clients for home-delivered meals have high nutritional risk scores.	FY 04: FY 03: FY 02:	FY 04: FY 03: FY 02:	1
<u>Transportation</u>			
A high percentage of clients rate transportation service as very good or better. -- <i>developmental</i>	FY 04: FY 03: FY 02:	FY 04: FY 03: FY 02:	6
<u>Information and Assistance</u>			
A high percentage of clients report that calls for information and assistance are answered quickly. <i>developmental</i>	FY 04: FY 03: FY 02:	FY 04: FY 03: FY 02:	6
<u>Home Care Services</u>			
Improve home care services satisfaction scores. -- <i>developmental</i>	FY 04: FY 03: FY 02:	FY 04: FY 03: FY 02:	6
<u>Caregiver</u>			
Improve caregiver support services satisfaction scores: -- <i>developmental</i>	FY 04: FY 03: FY 02:	FY 04: FY 03: FY 02:	6

Performance Measures Analysis—Client and Program Outcome Measures

IMPORTANT NOTICE: *The Administration on Aging entered into a contract with WESTAT, Inc. to conduct national performance outcome measures surveys for the following services in FY 2002: nutrition, transportation, home care, caregiver support, and information and assistance. The following is an analysis of preliminary data from these surveys. It demonstrates from the perspective of the consumer that the Aging network provides effective and useful services to elderly individuals.*

AoA has conducted five national surveys of elderly clients and a survey of family caregivers to obtain the assessment of clients regarding OAA services and to use the data as a basis for performance outcome measures. With the surveys, AoA obtained assessments from approximately 3,400 elderly individuals and caregivers, using sampling methods that allow AoA to make observations that are representative of OAA clients as a whole. The surveys of elderly clients were designed to assess the following service categories: congregate and home-delivered meals, information and assistance, homecare services, and transportation. The caregiver survey obtained caregiver assessments of the services provided to them and to the elderly they serve. The following are highlights from the national surveys for each of the categories surveyed.

Preliminary Results of FY 2002 National Outcome Measures Surveys

Nutrition Services:

- ***The Aging Network effectively targets meals to elderly individuals at high nutritional risk (data is from the Nutrition Screening Initiative questionnaire).***
 - 79 percent of home delivered meal clients are at high nutritional risk; 19 percent are at moderate risk.
 - 39 percent of congregate meal recipients are at high risk; 49 percent are at moderate risk.
- ***Home-delivered meals programs are targeted to the very old and to the very disabled.***
 - 58 percent of home delivered meal clients are 75 years of age or older; 65 percent of congregate meal clients are 75 years of age or older.
 - 83 percent of home delivered meal recipients have at least one limitation with the Activities of Daily Living (ADLs) and 99 percent have one or more limitations with the Instrumental Activities of Daily Living (IADLs); more specifically, 54 percent of home delivered meal clients had difficulty getting around at home while 65 percent reported difficulty getting around outside their homes.

- **41 percent of home delivered meal clients have limitations with three or more ADLs; this 41 percent constitutes a nursing home eligible population being cared for at home with support from the aging network.**

➤ ***There is a high degree of consumer satisfaction with meals programs provided through the network.***

- 95 percent of home delivered meal recipients report that they like the meals; 99.8 percent report they like the person who delivers it; 84 percent report that meals are always or almost always delivered on time.
- 91 percent of congregate meal recipients report they are very or somewhat satisfied with the way the meals taste; 99 percent report the meal site is pleasant and 100 percent report the meal site is safe.

Transportation Services:

➤ ***Individuals who use transportation services sponsored by AoA find these transportation services to be vital to their independence and well-being.***

- 33 percent of seniors using these services use them for "virtually all" of their trips.
- 48 percent "definitely get around more now than before they had this service."

➤ ***The AoA-funded transportation services are targeted to individuals who most need them.***

- Only 29 percent of those using these services have the possibility of driving instead.
- 63 percent of the riders are 75 years of age or older.

➤ ***Transportation services are highly regarded by the elderly who use them.***

- Over 80 percent rate the services as "excellent" or very good.
- 76 percent "would definitely recommend these services to a friend"
- The drivers who provide services get particularly high marks:
 - 85 percent are rated as "always polite"
 - 84 percent "always help passengers getting in and out of the vehicles when needed"
 - 65 percent "always help passengers getting in and out of their homes when needed"

Information and Assistance:

- 48 percent of calls were to obtain services and 36 percent were to obtain information.

- **Callers report a high level of satisfaction.**
 - 84 percent of callers were either very satisfied or satisfied with the way their call was handled.
 - 89 percent said they would recommend the service to a friend or colleague.
- **Responses are helpful.**
 - 85 percent of respondents said they received the information they were expecting.
 - 84 percent said the information received should resolve their issue.
 - 96 percent of callers said the person they spoke with understood them.
- **Responses are timely.**
 - 94 percent of callers reported that their call was answered within 5 rings.
 - 86 percent reported the phone was answered by a person (rather than a machine).
 - 85 percent who left voice mail reported a callback.

Home Care Services:

- The homemaker services sponsored by AoA are ***targeted to clients with a high degree of need who are at risk of losing their independence.***
 - 63 percent report annual household incomes below \$10,000.
 - 71 percent live alone.
 - 71 percent are age 75 and older.
 - Virtually all clients of homemaker services (98 percent) have at least one limitation in a range of home management activities called Instrumental Activities of Daily Living (IADLs).
 - Personal care limitations with such activities of daily living (ADLs) as bathing and dressing were reported by 80 percent of the homemaker clients; ***37 percent of homemaker service recipients report three or more ADL limitations which constitutes a level of frailty consistent with nursing home residents, i.e. 37 percent of homemaker service clients eligible for nursing home placement are receiving their care at home through AoA sponsored services.***
- ***Clients of homemaker services report high levels of satisfaction with the quality of services they receive.***
 - 84 percent said their homemaker is thorough.
 - 87 percent said the homemaker takes an interest in them.
 - 86 percent said the homemaker does things the way the client wants them done.

Caregiver Support Services:

- AoA sponsored caregiver services are ***provided to individuals (caregivers) who need the services.***
 - 24 percent have difficulty providing care because of their own physical limitations.
 - 37 percent are providing care for someone else.
 - 51 percent are providing all or nearly all of the care for the elderly care recipient.
 - 30 percent of caregivers are 65 years of age or older.
 - 65 percent of all care recipients are 75 years of age or older; 22 percent are 85 or older.
 - 45 percent are working; 10 percent stopped working to provide care.
 - 88 percent provide transportation for their care recipient; 79 percent help with meals or laundry; 73 percent help with financial matters.
- Caregivers receiving AoA funded services report that ***these services are vital to maintain the caregivers ability to provide services.***
 - 88 percent report that services have definitely or probably enabled them to provide care longer than would otherwise have been possible.
 - 72 percent of caregivers report the services have "helped a lot"; an additional 27 percent say the services have "helped a little."
- ***AoA sponsored caregiver services are highly regarded by those individuals who use them:*** 59 percent are "very satisfied" with the services received; another 36 percent are "somewhat satisfied."

Next Steps—Defining Outcome Measures Based on Surveys

The data presented above are based on preliminary survey results. As the data are finalized over the next few months, AoA will work with State and local representatives who assisted in the development of these surveys to identify specific measures, including performance targets for FY 2005, that can be used to measure program outcomes on an annual basis over time. To ensure that there is a continuous source of outcome data, AoA has again contracted with WESTAT to repeat the outcome measures surveys for FY 2003. In addition, at least four States will be conducting comparable State-level surveys in FY 2003, for performance measurement purposes. AoA will work to expand this number substantially in future years.

Goals and Targets

With the collection and analysis of National data in 2002, AoA will be prepared to establish performance targets for a varied set of outcome measures in the final FY 2004 annual performance plan. AoA will continue to sponsor the development of national, State and local performance outcome measurement projects. As AoA has with the development of GPRA measures as a whole, decisions on outcome measures will be iterative, and the agency, with input and guidance from the network, will continue to improve outcome measures over time. AoA has worked with statistical consultants to determine how statistical tools can be employed to derive national data for the performance outcome measures that are approved for use for the aging network, and is prepared within the next year to conduct a national survey. The results of the outcome measures project will be used to improve performance measures for AoA administered programs, and the status of project implementation and findings will be provided in all updates of AoA's performance plan submissions.

2.2 VULNERABLE OLDER AMERICANS

Program Description and Context

(numbers in thousands)	FY 2001 Enacted	FY 2002 Enacted	FY 2003 President's Budget	FY 2004 HHS Budget
Vulnerable Older Americans	\$14,181	\$17,681	\$17,681	\$17,681

AoA uses its measurement activity for the Ombudsman program to represent the broader budget activity "Vulnerable Older Americans," which also includes funding for other activities associated with the protection of the rights of elder individuals. Long-term care ombudsmen are necessary advocates for residents of nursing homes, board and care homes, and adult care facilities.

Ombudsman responsibilities outlined in Title VII of the Older Americans Act include:

- Identifying, investigating and resolving complaints made by or on behalf of residents;
- Providing information to residents about long-term care services;
- Representing the interests of residents before governmental agencies and seeking administrative, legal and other remedies to protect residents;
- Analyzing, commenting on and recommending changes in laws and regulations pertaining to the health, safety, welfare and rights of residents;
- Educating and informing consumers and the general public regarding issues and concerns related to long-term care and facilitating public comment on laws, regulations, policies and actions; and
- Promoting the development of citizen organizations to participate in the program and providing technical support for the development of resident and family councils to protect the well being and rights of residents.

Program Performance Analysis

Performance Measures Summary Table—Ombudsman Intermediate Outcome Measures

Performance Goals	Targets	Actual Performance	Notes
INTERMEDIATE OUTCOME MEASURES			
OMBUDSMAN MEASURE			
Maintain a high combined resolution / partial resolution rate for complaints in nursing homes.	FY 04: 75% FY 03: 74% FY 02: 70% FY 01: 70% FY 00: 70% FY 99: 71.48%	FY 04: FY 03: FY 02: FY 01: 76.7% FY 00: 74.1%✓ FY 99: 74.3%✓ FY 98: 70.6% FY 97: 72.1%	6
Improve combined resolution/ partial resolution rate for primary Aging network States (States and Territories)	FY 04: 7 States FY 03: 5 States FY 02: (New in 03)	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04	

Performance Measures Analysis—Ombudsman Intermediate Outcome Measures

A major goal of the Ombudsman Program is to enable residents of long-term care facilities and their families to be informed "long-term care consumers" and to facilitate the resolution of problems regarding care and conditions in long-term care facilities. To demonstrate that the network is targeting services to vulnerable individuals, ***data should show that a significant percentage of complaints are resolved each year.*** In FY 2003, at the urging of the Office of Management and Budget and the Office of the Secretary of HHS, AoA added a performance measure to foster ***improved performance*** by committing to increase resolution rates for five program States (States or Territories) that currently perform below the national average.

Results for Ombudsman Intermediate Outcome Measures

- **Complaint Resolution Measure:** For each of the years included in the table above, ***the network has achieved a high combined resolution/partial resolution rate in excess of 70 percent.*** For FY 2001, the rate has risen to over 75%.

Goals and Targets

Performance targets for FY 2003 and 2004 are based on the past and current performance of the network as reflected in the table above. Because of the successful overall performance of nursing home Ombudsmen in resolving complaints, AoA seeks to maintain performance at or near the levels established as national performance targets over the last few years. The national targets for FY 2003 and 2004 for resolving complaints have been increased to reflect that intention.

AoA is committed to continuously improve program performance where it is needed. To reflect this commitment for its Ombudsman program intermediate outcome measure, beginning with the FY 2004 performance plan, ***AoA targets to improve performance in five States in FY 2003 and seven States in FY 2004, for which Ombudsman complaint resolution percents are below the national complaint resolution percentage.***

2.3 SERVICES FOR NATIVE AMERICANS

Program Description and Context

(numbers in thousands)	FY 2001 Enacted	FY 2002 Enacted	FY 2003 President's Budget	FY 2004 HHS Budget
Grants to Indian Tribes	\$23,457	\$25,722	\$27,729	\$27,729

Between 213,000 and 395,000 American Indians and Alaska Natives over the age of 60 were identified in the 2000 Census. The lower number represents those individuals who identified themselves as "American Indian or Alaska Native alone" and the larger number represents those who identified themselves as "American Indian or Alaska Native alone or in combination with other races". Although older adults represent only about eight percent of the total American Indian and Alaska Native population, their numbers are increasing rapidly. This increase is due to better health and living conditions as well as the increasing number of people self-identifying as American Indian or Alaska Native. Today, older American Indians, Alaska Natives and Native Hawaiians can expect to live well into their eighties and nineties. This recent, but welcome trend will place even greater demands on home and community-based service delivery systems.

AoA's American Indian, Alaska Native, and Native Hawaiian Program--Title VI of the OAA — is responsible for serving as the Federal advocate on behalf of older Native Americans, coordinating activities with other Federal departments and agencies, administering grants to Native Americans for home and community-based services, and collecting and disseminating information related to the problems of older Native Americans.

Under Title VI of the OAA, AoA annually awards grants to provide home and community-based and nutrition services for American Indian, Alaska Native and Native Hawaiian older adults living in the Title VI service area. In 2001, grants were awarded to 233 American Indian and Alaska Native tribal organizations representing nearly 300 tribes, and two organizations serving Native Hawaiian elders.

In addition to nutrition services, the Title VI program funds home and community-based services such as information and assistance, transportation, chore services, homemaker services, health aide services, outreach, family support, and legal assistance. [There is also a Native American Caregiver Support Program, established in the 2000 amendments to the OAA; however, the funding for this appears in another OAA budget line.]

Performance Measures Summary Table—Native Americans Program

Performance Goals	Targets	Actual Performance	Notes
Initially increase and then maintain units of service in the following categories:	(numbers in thousands)	(numbers in thousands)	
<u>Home-delivered meals</u>	FY 04: 1,850 FY 03: 1,850 FY 02: 1,850 FY 01: 1,795 FY 00: 1,632 FY 99: 1,456	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 2,166 FY 00: 1,778 FY 99: 1,680 ✓ FY 98: 1,624 FY 97: 1,525	1
<u>Congregate meals</u>	FY 04: 1,650 FY 03: 1,650 FY 02: 1,650 FY 01: 1,583 FY 00: 1,439 FY 99: 1,322	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 1,440 FY 00: 1,348 FY 99: 1,290 FY 98: 1,354 FY 97: 1,366	1
<u>Transportation service units</u>	FY 04: 732 FY 03: 732 FY 02: 732 FY 01: 732 FY 00: 665 FY 99: 763	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 735 FY 00: 699 FY 99: 702 FY 98: 719 FY 97: 680	6
<u>Information/referral service units</u>	FY 04: 747 FY 03: 747 FY 02: 747 FY 01: 747 FY 00: 679 FY 99: 632	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 659 FY 00: 651 FY 99: 633 FY 98: 715 FY 97: 705	6
<u>In-home service units</u>	FY 04: (discontinued) FY 03: 970 FY 02: 953 FY 01: 953 FY 00: 866 FY 99: 742	FY 04: 02/06 FY 03: 02/05 FY 02: 02/04 FY 01: 961 FY 00: 929 FY 99: 942 FY 98: 1,032 FY 97: 882	
<u>Other services</u>	FY 04: (discontinued) FY 03: 660 FY 02: 650 FY 01: 650 FY 00: 591 FY 99: 512	FY 03: 02/05 FY 02: 02/04 FY 01: 776 FY 00: 682 FY 99: 702 ✓ FY 98: 756 FY 97: 583	

Program Performance Analysis

For the most part, Native American programs have maintained service levels, adjusted for inflation, in the face of level funding. The FY 2001 data indicate successful results for all performance targets except for information/ referral services and congregate meals. However, service provision overall remains stable for this program.

Beginning in FY 2004, AoA will eliminate two output measures for this program, and track the same measures it tracks for the State home and community-based programs: meals, transportation, and information and referral.

Locally administered home and community-based programs and services are an important component of the long-term care delivery system. Indian tribes have pursued the development of appropriate home and community-based long-term care services to enable their elders to remain as independent as possible in community settings of their choice. Through 236 grants provided by AoA, a variety of in-home support services were provided to tribes, tribal organizations and Native Hawaiian organizations during FY 2001:

- More than 61,000 older American Indians, Alaska Natives and Native Hawaiians received a variety of in-home services including personal care services, homemaker services, health aide services, case management assistance, and family support.
- Approximately 735,000 rides were provided to older Native American adults to meal sites, medical appointments, grocery stores and other destinations.
- Nearly a million units of individual and family support services, such as visitation and respite, were provided to elders and their families. More than 650,000 units of information and assistance on issues dealing with Social Security, food stamps, and other topics were provided to elders and their families.

Recipients of rides were able to increase their access to programs and services and maintain greater independence within their communities. Recipients of information and assistance have increased information about their right to receive Social Security, food stamps and other services aimed at improving their health and standard of living.

2.4 AOA RESEARCH AND DEVELOPMENT

(numbers in thousands)	FY 2001 Enacted	FY 2002 Enacted	FY 2003 President's Budget	FY 2004 HHS Budget
Research and Development	\$46,626	\$52,119	\$41,716	\$41,716

AoA's Research and Development projects are intended to establish programs for model demonstrations, applied research and national resource centers to produce best practices, useful knowledge and systems improvements that point policy makers and program administrators to well-reasoned courses of action in the field of aging. Because these projects and other evaluation activities support the fundamental program characteristics of the aging network programs, AoA will not establish a separate set of performance measures for these activities. The ability of AoA and the network to achieve the service, outcome and systems performance goals of the OAA programs relies in part on the projects and activities carried out under this program category. Significant new program activity and program improvements have their roots in such research and development projects, including nutrition programs for the elderly, the new caregiver program, and the long-term care ombudsman program.

2.5 SENIOR MEDICARE PATROLS & TECHNICAL ASSISTANCE CENTERS

Program Description and Context

(numbers in thousands)	FY 2001 Enacted	FY 2002 Enacted	FY 2003 President's Budget	FY 2004 HHS Budget
Senior Medicare Patrols and Technical Assistance Centers	\$1,500	\$2,000	\$3,000	\$3,000

HHS, particularly the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG), has placed significant emphasis on the identification and reduction of billions of dollars of fraud and waste in the Medicare program. AoA has played an active role in addressing this national problem through two legislative sources.

Health Insurance Portability and Accountability Act (HIPAA) of 1996. Under the HIPAA, AoA works in partnership with the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General (OIG), the Department of Justice, and other Federal, State, and local partners to educate and inform older Americans how they can play an important role in protecting the benefit integrity of the Medicare and Medicaid programs. **AoA's primary efforts under this initiative have been to: 1) fund State and local projects to train aging network professionals to recognize and report potential instances of waste, fraud, and abuse; 2) develop and disseminate consumer education materials to beneficiaries; and 3) support technical assistance efforts designed to share and replicate common strategies and successful practices among federal, state and local officials, health care professionals, community service providers who serve older Americans, and beneficiaries and their families.** The funding from HIPAA is now primarily used to fund technical assistance centers that support the "Senior Medicare Patrols."

Omnibus Consolidated Appropriations Act of 1997: Beginning with the Omnibus Consolidated Appropriations Act of 1997 (P.L. 104-209), AoA has been charged with establishing innovative community-based projects that seek to utilize the skills and expertise of retired professionals in educating older Americans regarding how to help protect the benefit integrity of the Medicare and Medicaid programs. During FY 2001, AoA funded 52 such community-based projects, known as "Senior Medicare Patrol Projects," in 47 States, plus the District of Columbia and Puerto Rico. These Senior Medicare Patrol Projects recruit and train retired professionals, such as doctors, nurses, teachers, lawyers, accountants, and others to work in their communities, teaching beneficiaries how to take an active role in protecting their Medicare card numbers and their health care.

Program Performance Analysis

Performance Measures Summary Table— Senior Medicare Patrol Measures

Performance Goals	Targets	Actual Performance	Notes
SENIOR MEDICARE PATROL MEASURES			
<u>Trainers</u>			
Increase the number of trainers who educate beneficiaries	FY 04: (discontinued) FY 03: 56,800 FY 02: 54,800 FY 01: 41,100 FY 00: 17,125 FY 99: (new in 2000)	FY 04: 02/05 FY 03: 02/04 FY 02: 57,061 FY 01: 48,076 FY 00: 39,300 trained ✓ FY 99: 13,700 (baseline) (a)	
<u>Volunteers</u>			
Increase the number of beneficiaries who are educated by the volunteer trainers	FY 04: 1,200,000 FY 03: 600,000 FY 02: 500,000 FY 01: (new in 2002)	FY 04: 02/05 FY 03: 02/04 FY 02: 955,000 FY 01: 570,000 FY 00: 350,000 (baseline) (b)	
INTERMEDIATE OUTCOME MEASURES			
<u>Inquiries</u>			
Increase the number of substantiated complaints generated through AoA's activities (i.e. complaint results in some action taken).	FY 04: 3,000 FY 03: 2,500 FY 02: 380 FY 01: 280 FY 00: 200 FY 99: (new in 2000)	FY 04: 02/05 FY 03: 02/04 FY 02: 2,708 FY 01: 2,190 FY 00: 1,241 FY 99: 133 (baseline) (c)	
Previous reports and plans may have "percentages" or "percents" shown for some of the targets. We have concluded that using percents or percentages may have caused some confusion for some readers. We have converted all targets to "numbers." We believe that this will help to eliminate any confusion. Also, all numbers, for targets and results, are "cumulative" since inception of the projects – including projects funded under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. (a.)The cumulative total includes volunteers who were trained under HIPAA. This effort was succeeded by the "Senior Medicare Patrol" projects authorized by the Omnibus Consolidated Appropriations Act of 1997 (P. L. 104-209). (b) Cumulative including beneficiaries educated under the authority of HIPAA. (c) Baseline total is cumulative including complaints substantiated under HIPAA.			

Performance Measures Analysis—Senior Medicare Patrol Program

AoA has elected to employ a set of fundamental results measures that reflect the agency's commitment of educating and informing older Americans how to take an active role in their health care, thereby helping to maintain the benefit integrity of the Medicare and Medicaid programs. The DHHS OIG collects performance data from AoA's Senior Medicare Patrol Projects semi-annually.

To demonstrate that the network is educating older Americans to take an active role in their health care and protect the integrity of Medicare and Medicaid services, the data should show an increase in the number of trainers who educate beneficiaries, an increase in the number of beneficiaries educated by volunteer trainers, and an increase in the number of complaints that have been reported and acted upon as a result of the AoA programs.

To contribute to the reduction of output measures in the FY 2004 report, AoA will discontinue its measure of the number of trainers.

Results for the Senior Medicare Patrol Program

For the measures presented in the table above, the data indicates that **the aging network effectively educates and informs older Americans how to take an active role in their health care and maintain the integrity of the Medicare and Medicaid systems.**

- **Volunteers Trained Measure:** The first measurement is directed at increasing the number of volunteers trained by AoA's grantees, who in turn educate an increasing number of beneficiaries regarding how to take an active role in protecting their health care. In FY 1999, the Senior Medicare Patrol Projects were just beginning to develop their training activities and materials. However, by the end of FY 1999 we had trained 13,700 (on a cumulative basis) community volunteers under the HIPAA and Senior Medicare Patrol projects. During FY 2000 and beyond, materials and effective training strategies were more widely utilized by the grantees, which meant that we could increase the target of the number of volunteers trained to over 57,000 by FY 2002.

The performance for FY 2002 exceeded the target, by reaching approximately 57,000 volunteers trained. We do not anticipate that the grantees will train as many new volunteers during future years because the effort will build on the large pool of experienced volunteers who will continue to conduct sessions during those years. Also, because AoA wants to focus on trained beneficiaries and their results, this measure is discontinued in FY 2004.

- **Beneficiaries Educated Measure:** The second measurement is directed toward increasing the number of beneficiaries who are educated by the volunteer trainers. This measurement was new in FY 2002. It is the beneficiaries, who have to learn to detect possible fraud, waste and abuse in the Medicare payments. AoA substantially exceeded its FY 2002 target. The "trainers" trained over 950,000 beneficiaries for both HIPAA and the Senior Medicare Patrol projects. As a result of this unexpected level of training activity, AoA has increased its target for FY 2004, to 1,200,000 beneficiaries trained since inception of these projects.
- **Inquiries Submitted and Acted Upon Measure:** The third measurement consists of the number of inquiries submitted by AoA's projects and volunteers to health care providers, Centers for Medicare and Medicaid Services (CMS), the OIG, and other appropriate sources that result in some action being taken. In FY 1999, this system of reporting was just beginning to be developed and AoA's projects started with a baseline of 133 cases (for both the HIPAA and Senior Medicare Patrol projects) that resulted in some sort of corrective action being taken. **In FY2002, the projects exceeded the projected target, with more than 2,700 cases that resulted in some action being taken.**

Goals and Targets

Performance targets for FY 2004 are based on the past and current performance of the network as reflected in the table above. Because the network significantly exceeded performance targets in all three of the performance measures, AoA has increased the FY04 targets. **AoA's commitment to increased performance is reflected in the increase in FY04 performance targets for the Senior Medicare Patrol Program.**

2.6 PROGRAM MANAGEMENT

Program Description and Context

(numbers in thousands)	FY 2001 Enacted	FY 2002 Enacted	FY 2003 President's Budget	FY 2004 HHS Budget
Program Direction	\$17,216	\$18,053	\$17,986	\$17,501

From the outset of GPRA implementation, AoA has agreed with the HHS principle that management challenges should be addressed in the GPRA context, and included two process measures in its original FY 1999 annual performance plan. With the FY 2002 plan, AoA reestablished its commitment to include management measures in the annual performance plan by including additional management measures for financial management, program reporting, and workforce planning. The Annual Performance Plan for FY 2004 takes an additional step in that commitment by adding new performance measures that are specifically related to the five President's Management Agenda initiatives identified for FY 2004. In FY 2004, the hiring measurement based on the Workforce Plan was discontinued.

AoA retains for FY 2004 the performance measures added for FY 2002, which commit the agency to a clean financial opinion, to using a formal workforce plan, and to improving the timeliness of program data reporting. With the FY 2004 plan, AoA defines a performance target for the workforce planning measure and adds two related measures: to increase the agency's employee to supervisor ratio and to reduce the average grade of agency employees. AoA also adds a performance measure to make greater use of performance based contracting and another to reflect our implementation of the electronic submission and processing of selected agency grant applications.

AoA's performance measures for management activities now cover the following areas:

- **Financial Management**
- **Acquisitions/Grants Management/E-Government**
- **Workforce Planning and Restructuring**
- **Program Information Collection and Reporting**

The areas covered and the measures employed track very closely with the management priorities of OMB and HHS.

Program Performance Analysis

Performance Measures Summary Table—Program Management Measures

Performance Goals	Targets	Actual Performance	Notes
PROGRAM MANAGEMENT MEASURES			8
<u>Financial Management</u>			
Results of most recent CFO Audit of AoA Financial Statements.	FY 04: Clean Opinion FY 03: Clean Opinion FY 02: Clean Opinion FY 01: Clean Opinion FY 00: (New in FY 01) FY 99: Not applicable	FY 04: 02/05 FY 03: 02/04 FY 02: Same as 01 FY 01: Clean Opinion	
<u>Strategic Management of Human Capital</u>			
A high percentage of AoA hires will be based on a formal AoA Workforce Plan.	FY 04: (Discontinued) FY 03: 80% FY 02: 80% FY 01: (New in FY 02)	FY 04: FY 03: FY 02: 100%	
Increase the ratio of employees to supervisors.	FY 04: 5.0 to 1 FY 03: 5.0 to 1 FY 02: (New in FY 03)	FY 04: FY 03: FY 02: 5.2 to 1 FY 01: 4.3 to 1	
Decrease the average grade of AoA career employees.	FY 04: 13.0 FY 03: 13.0 FY 02: (New in FY 03)	FY 04: FY 03: FY 02: 12.3 FY 01: 13.5	
<u>Acquisitions/Grants Management/E-Government</u>			
Increase the percentage of procurement dollars that are subjected to performance-based contracts.	FY 04: 20% FY 03: 20% FY 02: 20% FY 01: (New in FY 02)	FY 04: FY 03: FY 02: FY 01: 0% (baseline)	
Increase the percentage of discretionary grant applications that are submitted and processed electronically, including via the Internet.	FY 04: 10% FY 03: 10% FY 02: (New in FY 03)	FY 04: FY 03: FY 02: FY 01: 0% (baseline)	
<u>Program Information Collection and Reporting</u>			
Reduce the time lag (in months) for making NAPIS data available for GPRA purposes and for publication.	FY 04: (Discontinued) FY 03: 15 months FY 02: 15 months FY 01: 15 months FY 00: (New in FY 01)	FY 04: FY 03: FY 02: FY 01: 15 months FY 00: 19 months FY 99: 22 months FY 98: 26 months	

Results for Program Management Measures

Financial Management Measures: In FY 2001, AoA received a clean opinion on the audit of its FY 2000 financial statements (balance sheet), and in FY 2002 received a clean opinion on the audit of its complete FY 2001 financial statements. As reflected in the management priorities circulated by OMB for the FY 2003 budget process, improving financial management is a significant management priority, and the achievement of a clean financial opinion is a fundamental indicator of financial management quality. **AoA is committed to expanding the annual audit to its full financial statements, and to receiving a clean opinion in the audit each year.** AoA will retain this measure as a fundamental indicator of financial management quality and commitment in its annual performance plans.

Strategic Management of Human Capital Measures: An extensive AoA review of workforce and structural conditions found that improvements are necessary and achievable in: 1) "delaying" the organization, 2) grade structure, and 3) skill mix. To track its accountability for implementing improvements, AoA included three performance measures related to workforce planning and restructuring in its FY 2003 and FY 2004 GPRA performance plans. ***In FY 2002, AoA met the FY 2003 targets for by increasing the employee to supervisor ratio for the agency and by achieving a measurable reduction in the average grade of employees.*** AoA will seek to maintain these significant improvements in FY 2003 and 2004. In the interests of reducing the number of measures in the AoA performance plan, the agency will discontinue the performance goal that requires that eighty percent of AoA new-hires will be in strict conformance with the priorities of the agency's formal workforce plan. Anticipating that AoA will comply with that measure in FY 2002 and 2003, we will track future compliance with this objective internally.

Acquisitions/Grants Management/E-Government Measures: AoA has initiated work to apply the efficiencies of electronic transactions to one of its most significant operational activities, and will pursue the application to a second such activity within the next year. AoA has initiated work to apply e-government solutions to its grants processing efforts, and will work with State and local government entities to identify the feasibility of applying such technology to the submission of detailed program information requirements.

The grants application process is one of AoA's most significant workload processes, and involves significant staff and related resources on the part of AoA and potential grantees. Believing that electronic processes offered a significant opportunity for improved efficiency for AoA and its grantees, AoA has developed and is prepared to test information technology that will allow grantees to apply for AoA funding electronically, including by way of the Internet. To ensure maintenance and the realization of these electronic process improvements, AoA has included a performance goal in its annual GPRA

performance plan that calls for the agency to increase the percentage of discretionary applications that are submitted and processed electronically to 10 percent by FY 2003.

AoA is also committed to improve performance in an activity related to OMB's initiative to expand electronic government, which is specifically referenced in section 31.9 of OMB Circular A-11 (2001).

AoA has complied with an HHS initiative for improved agency planning to increase the use of performance-based contracts. Planned AoA activities include:

- Management review of contract areas that would benefit from performance-based contracting;
- Extensive staff training in the methods and processes of performance-based contracts; and
- Creation of integrated project teams to achieve broad participation in defining contract results, performance standards and measures, and quality assurance surveillance plans.

AoA has also included a performance measure in GPRA performance plans for the last three years to increase the use of performance-based contracts in its procurement activities to 20 percent of its procurement dollars.

Program Information Collection and Reporting: Reflecting the firm commitment of the agency to improve the quality, reliability, and timeliness of data from the National Aging Program Information System (NAPIS), and to reduce the burden that it imposes on the network, the FY 2002 plan introduced a developmental measure that reflects a necessary system outcome.

Recognizing the need for immediate improvement in the timeliness and quality of data provided under the State Program Report (SPR), AoA has engaged in the following during FY 2001:

- An extensive review of the SPR requirements particularly as they affect the timing of reporting and the quality of data, and
- An acceleration of the tabulation and certification of FY 1999 SPR data and the collection of the FY 2000 data.

The review has resulted in the following related to the SPR information collection system.

- AoA accelerated the initial tabulation of FY 1999 data to make it available for the FY 2002 performance plan and report.
- AoA accelerated the final certification of FY 1999 data, to the effect of making the data available for this performance report submission and four months earlier than the FY 1998 data.
- AoA has accelerated the collection and certification of the FY 2000 data with the objective of making that data available for the FY 2003 annual performance plan and report, which will be submitted

to Congress in February, two months earlier in the year than the FY 2002 plan was submitted.

- AoA has formed a team of AoA, state and area agency representatives to modify the SPR over the next year, with the principal objective of reducing the burden and complexity of reporting.

AoA has finalized the GPRA performance measure that appears in this annual GPRA performance plan. It calls for AoA to reduce the time required for making data available for GPRA purposes and for the public from 26 months for the FY 1998 data to 15 months for the data for fiscal years 2001 and 2002. ***The use of final NAPIS data for FY 2001 in this plan and the availability of State NAPIS data on the AoA website reflects that AoA successfully achieved the goal of reducing the NAPIS data lag from 26 to 15 months over a two-year period.***

In the interests of reducing the number of measures in the GPRA plan, AoA will discontinue this performance measure in the GPRA plan beginning in FY 2004. We expect that AoA and the States will achieve the maximum reduction in the timing of performance information by FY 2003. The agency will continue to monitor the timeliness of program data submissions internally.

III. APPENDICES to the PERFORMANCE PLAN

APPENDIX 1

Linkage to the HHS and Agency Strategic Plans

Part 1 of this performance plan provides a summary presentation of the linkage between the AoA GPRA performance plan and the HHS Strategic Plan. The following chart is intended to provide a more descriptive and definitive illustration of the detailed links between individual AoA program activities and the detailed goals and objectives in the HHS Strategic Plan.

HHS Strategic Goal 1: Reduce the Major Threats to Health and Well-Being of Americans

HHS Strategic Objective 1.1: Reduce Risky behaviors and other factors that contribute to the development of chronic diseases, especially diabetes and asthma.

AoA Program	Performance Goal
Home Delivered Meals	Increase the number of home-delivered meals provided and maintain a high percentage of new clients for home delivered meals who have high nutritional risk scores.
Congregate Meals	Maintain the number of congregate meals served.
Programs for American Indians, Alaska Natives, and Native Hawaiians	Improve the health and well-being, and reduce social isolation, among older American Indians, Alaska Natives and Native Hawaiians by maintaining the level of provision of community-based services.

HHS Strategic Goal 6: Improve the Economic and Social Well-being of Individuals, Families, and Communities, Especially Those Most in Need

HHS Strategic Objective 6.2: Increase the Proportion of Older Americans Who Stay Active and Healthy

AoA Program	Performance Goal
Community Based Services: Targeting Measures	Improve poor client service percentages for primary Aging network entities-- developmental
Community Based Services: Targeting Measures	A significant percentage of OAA Title III service recipients are poor.
Community Based Services: Targeting Measures	A significant percentage of OAA Title III service recipients are minorities.
Community Based Services: Targeting Measures	A significant percentage of OAA Title III service recipients live in rural areas

Community Based Services: Targeting Measures	Improve rural client service percentages for primary aging network -- <i>developmental</i>
Community Based Services: Service Measures – Nutrition	Increase the number of home-delivered meals provided and maintain the number of congregate meals served.
Community Based Services: Service Measures – Transportation	Maintain the number of one-way rides provided.
Community Based Services: Service Measures – Information and Assistance	Maintain the number of information and assistance contacts.
Community Based Services: Client Outcome Measures – Nutritional Risk	The average nutritional risk score for established OAA clients will be lower than the average score for new clients. -- <i>developmental</i>
Community Based Services: Client Outcome Measures – Transportation Satisfaction	A high percentage of clients rate transportation service as very good or better. - - <i>developmental</i>
Community Based Services: Client Outcome Measures – Information and Assistance Satisfaction	A high percentage of clients report that calls for information and assistance are answered quickly. -- <i>developmental</i>

HHS Strategic Objective 6.3: Increase the Independence and Quality of Life of Persons with Long-Term Care Needs

AoA Program	Performance Goal
Protection of Vulnerable Older Americans – Long Term Care Ombudsman Outcome Measures	Maintain the combined resolution / partial resolution rate of 74 percent of complaints in nursing homes.
Protection of Vulnerable Older Americans – Long Term Care Ombudsman Outcome Measures	Improve combined resolution/ partial resolution rate for primary aging network entities (States and Territories) -- <i>developmental</i>
Community Based Services: Home Care Satisfaction Measure	Improve home care services satisfaction scores. -- <i>developmental</i>
Community Based Services: Caregiver Support Services Measure	Improve caregiver support services satisfaction scores -- <i>developmental</i>
Community Based Services: Caregiver Support Services Targeting Measure	Increase the ratio of family caregivers to registered clients-- <i>developmental</i>

HHS Strategic Goal 8: Achieve Excellence in Management Practices**HHS Strategic Objective 8.2: Improve Strategic Management of Human Capital**

AoA Program	Performance Goal
Program Management	Increase the ratio of employees to supervisors
Program Management	Decrease the average grade of AoA career employees
Program Management	A high percentage of AoA hires will be based on a formal workforce plan.

HHS Strategic Objective 8.3: Enhance the efficiency and effectiveness of competition between public and private service providers

AoA Program	Performance Goal
Program Management	Increase the percentage of procurement dollars that are subjected to performance-based contracts.

HHS Strategic Objective 8.4: Improve Financial Management.

AoA Program	Performance Goal
Program Management	Receive a clean opinion in the most recent audit of AoA financial statements.

HHS Strategic Objective 8.5: Enhance the use of electronic commerce in service delivery and record keeping.

AoA Program	Performance Goal
Program Management	Increase the percentage of discretionary grant applications that are submitted and processed electronically, including via the Internet.

APPENDIX 2

Changes and Improvements over the Previous Year

Because AoA made significant modifications to its GPRA performance plan for FY 2002 and FY 2003, the modifications for FY 2004 are far less significant. We believe strongly that it is important to maintain continuity in the performance plan, and repeated wholesale modifications are not warranted.

AoA's most significant changes for FY 2004 are the significant reduction of measures for program management to address the priorities of the Administration and the Secretary of HHS. The initial FY 2004 plan includes targeting, systems and service measures for the plan, and retains the descriptive information related to the development of outcome measures for this and other programs as well.

The agency has also significantly reduced its discussion of budget linkage in the introduction to Part 2 of the plan, adding significant analytical linkages between the agency's performance measures and its FY 2004 budget initiatives.

Finally, the agency has focused intentionally on reducing the length of the performance plan and report. In the past, we relied on narrative descriptions of accomplishments because quantitative measures were not compelling. With the revisions incorporated for the prior budget cycles, AoA believes that such narrative presentations are no longer appropriate.

APPENDIX 3

Approach to Performance Measurement

Methodology and Rationale

The fundamental elements of AoA's approach to performance measurement are consistent with the guidelines established by the Department of Health and Human Services because AoA shares many of the same measurement challenges that other HHS components face. AoA is the lead HHS component for support programs for elderly individuals, which are administered day-to-day by State and local governmental entities and numerous business and non-profit service providers. This fundamental program partnership dictates that AoA approach performance measurement mindful of the needs and constraints of the non-Federal partners that share program authority and responsibility.

AoA has instituted performance measurement with the approach of utilizing existing information resources to the full extent possible, and reducing new and potentially burdensome information gathering to that which is important to program assessment and which is consistent with views of the partnership. AoA was limited in its first performance plans by the lack of mature, reliable data because of the status of implementation of a new information management system: The National Aging Program Information System (NAPIS). As a result, performance measures in the early GPRA plans were limited for the most part to output measures associated with service unit counts.

Beginning in FY 2002, AoA completely restructured its performance plan, particularly for its large State and community-based programs. To illustrate for that program, AoA defined performance measures that reflect the achievement of the aging network in: **targeting** services to elderly individuals in need, establishing an effective **system** of services utilizing funding from multiple sources, maintaining **service** outputs across a variety of domains, and producing **outcomes** that are relevant to the network and focus on consumer assessment.

Consistent with the improvements reflected in the FY 2002 performance plan, for FY 2003 AoA illustrates how its measures reflect a broad logic model that is comparable to that used by entities such as the United Way of America for social service programs. In the model, AoA identifies a mix of output, intermediate outcome, and end outcome measures associated with inputs provided by AoA and other program entities.

AoA continues to face a number of performance measurement constraints that are common to HHS programs.

- AoA relies on State and local governmental entities and service providers for the data required to measure performance. Because of the complex relationships, AoA cannot expect to have data available for GPRA

purposes within six months of the end of a fiscal year. In previous years, AoA did not anticipate having data available for two years after the end of the fiscal year, but through our work within AoA and with the cooperation of State and local agency representatives, we have already reduced those time frames.

- Like other HHS components, AoA is one of many providers of services to individuals, and can neither reasonably attribute broad changes in the characteristics and conditions of large population groups to its program activities, nor reasonably project measurable changes in significant population groups over short periods of time. These factors limit both the choice of measures available to AoA for GPRA purposes and the performance targets the agency can reasonably expect to achieve.
- Over the years, AoA has represented a relatively stable source of service support to elderly individuals across the country, and so cannot expect on an annual basis to produce broad based changes, increases or improvements in the results that are produced through the aging network. As a result, AoA and the aging network are in the process of defining levels of performance that reflect significant performance year in and year out, and which, if not met would result in the need for evaluation and enhanced program support.

These constraints do not hinder AoA action to use GPRA and performance measurement as important tools for program assessment, but they force the Agency to recognize the limits and the proper uses of this assessment tool. GPRA must be used in combination with other assessment mechanisms and information sources to "inform" program assessment and planning. With reasoned use and realistic expectations for this assessment tool, program managers throughout AoA and the aging network will increasingly realize the value of ongoing performance measurement. By facing and addressing these performance measurement challenges directly, AoA is developing a performance measurement program that has the potential to be useful to program managers and decision makers for years to come. HHS has correctly fostered an "iterative" approach to the implementation of GPRA and performance measurement. As AoA's GPRA performance measures mature and performance trends emerge, program executives and managers throughout AoA and HHS, and decision makers outside the Department, can expect to use trend data to seek the coordinated improvement of AoA and related HHS programs on an ongoing basis. The data will support agency efforts for: 1) assessing program activity and results, 2) engaging in program evaluation where deeper assessment is required, 3) redefining program strategies to produce improved results, and 4) modifying future performance targets to be consistent with available resources and up-to-date priorities and policy decisions.

Presentation

The presentation of this plan and report is organized in accordance with the standardized presentation format established by and for the agencies of the Department of Health and Human Services (HHS). AoA fully supports HHS's efforts to present performance measurement data under GPRA in a manner that is meaningful for Federal executive and legislative branch decision makers. Since the enactment of GPRA in 1993, the Office of Management and Budget (OMB), the General Accounting Office (GAO), and HHS have provided leadership that will allow Federal program components to continue the development of meaningful, realistic and effective performance measurement programs.

Appendix 4

Data Verification, Validation and Other Data Issues

AoA has continued to make progress in the two data initiatives highlighted prominently in the FY 2002 performance plan. AoA and State agencies engaged in a formal assessment effort that has resulted in the certification of FY 1999 and FY 2000 data months earlier than originally anticipated.

AoA has initiated a process to revise routine information collection activities to reduce reporting burden, improve timeliness and reliability of data, and incorporate reporting for the National Family Caregiver Support Program into the standard data collection process. AoA and the network continue to focus on the assessment of quality through the consumer, where it counts the most, at the community level, through the Performance Outcome Measures Project, and have initiated efforts to conduct a national survey of performance outcomes within the next year.

As indicated in the introduction to this performance plan and report, AoA and the aging network face a significant challenge in obtaining data to measure performance for programs of this kind. For the sake of context, it is important to reiterate those challenges here while addressing the extensive processes that AoA and the States utilize to improve the validity and reliability of the NAPIS data. All levels of the aging network, from AoA through the state and area agencies on aging to local centers and service providers, know well the challenge of producing client and service counts by critical program and client characteristics for a program which *coordinates* service delivery through approximately 29,000 local providers. Many OAA program services do not require a one-time registration for service on the part of clients; eligible clients may obtain services on an ad hoc and irregular basis. This makes the tracking of services to individuals and the generation of "unduplicated" counts of clients a very difficult task at the local level, particularly if local entities lack information technology that simplifies client and service record-keeping and information management. Federal and State reviews of data provided for FY 1997, 1998 and 1999 under NAPIS suggest that significant limitations in the adequacy of information infrastructure at the local level inhibit their ability to routinely and consistently produce the data that are required by law for the Older Americans Act programs and form the basis for many of AoA's GPRA performance measures. Extensive and repeated Federal and State efforts to provide technical assistance and to isolate and correct common data problems have been helpful for local areas in the majority of States and for most data elements required by the OAA through NAPIS. Nevertheless, much remains to be done to ensure that local service providers and area agencies have the capacity to reliably provide important data without excessive burden.

Technical Assistance, Standard Software Packages, Electronic Edits

AoA and the State units on aging have long recognized the effects that local capacity limitations could have on the generation of reliable data for programs and services of this type, and have taken significant steps to support local entities in producing the NAPIS data. There are at least two commercial packages now available to States and local entities to assist them in the preparation of the NAPIS data. These packages have fostered far greater consistency in the data generated for NAPIS than was possible in the early years of implementation. AoA developed an extensive set of electronic edits for all data elements, which are applied to the electronic submissions of State entities. AoA contractors work with State data administrators to correct data elements that fail electronic edits to ensure that data meet standard logic checks. Following standard electronic checks, knowledgeable AoA regional and central office staff conduct extensive reviews of edited data for "reasonableness," to ensure that significant value changes from one year to another reflect program circumstances and not the limitations of the program data. These processes have been extremely slow, burdensome and time consuming, and they must be modified. AoA and State agency representatives are investigating ways to streamline the data verification and validation process without compromising data quality.

Despite the data challenges that the network is addressing and the time-consuming validation processes that remain in place at the present time, AoA and the network have been able to certify the FY 1999 data cited in this report. The FY 1999 data are final. Nevertheless, AoA and the States must immediately engage in a comparable exercise of verification and validation before data for FY 2000 can be utilized for performance reporting purposes. AoA and the States will review a significant number of individual data items, which are generated from data reported by local components, for accuracy and validity.

AoA and its program partners have initiated an assessment of the data requirements of the OAA and will consider alternatives to the collection of the most complicated data that cause most of the burden and validity problems. This will be done in conjunction with agency efforts to renew approval of NAPIS data collection efforts under the Paperwork Reduction Act. AoA will work with State and local program representatives to improve their understanding of HHS's performance measurement principles, and better demonstrate the constructive uses of performance information to improve programs. AoA and State and local representatives will together assess the potential linkages of the performance outcome and service data that AoA will use for GPRA performance measurement purposes. Together we will seek to identify the correlation between service measures and program outcomes to demonstrate the value of collecting data on client and service characteristics on an ongoing basis.

AoA and the aging network face a similar challenge with the measurement of outcomes. Although we have made significant progress with the initial development and testing of outcome measures, we do not have national baselines for outcomes to set targets yet. Because of AoA's Performance Outcome Measures Project, which was expanded to approximately 30 area agencies in 16 pilot States in FY 2000, AoA was able to conduct national performance outcome measures surveys for the following services in FY 2002: nutrition, transportation, home care, caregiver support and information and assistance. Preliminary results have just become available which will allow the Agency to establish performance measure baselines for FY 2002, and performance measure targets for FY 2005.

Because of the data limitations addressed in this Appendix, AoA classifies many of its GPRA performance measures as "developmental." This classification means that although AoA will immediately make use of available data in the context of the GPRA performance plan and report, the measures and the data on which they are based lack the maturity to directly support decision-making immediately. In fact, this is not unusual for the assessment of performance for health and human service programs. As the Department has observed in previous HHS performance plan and report summaries, performance measurement data will become more useful over time as performance measures mature and trends in performance can be observed.

APPENDIX 5

Performance Measurement Linkage with the Budget

Budget Linkage Table
(\$ Amounts in 000's)

AoA FY 2002 Performance Plan Areas	Program/Budget Line Items	FY 2001 Enacted	FY 2002 Enacted	FY 2003 President's Budget	FY 2004 HHS Budget
Community-Based Services: Targeting Measures System Measures Service Measures Client and Program Outcome Measures	Supportive Services and Centers Congregate Meals Home-Delivered Meals Preventive Health Services Caregivers (NFCSP)	\$1,151,462	\$1,235,766	\$1,238,232	\$1,238,232
Vulnerable Older Americans	Vulnerable Older Americans	\$14,181	\$17,681	\$17,681	\$17,681
Services for Native Americans	Grants to Indian Tribes (Native American Caregiver Support program funding included in "Community-Based Services" above)	\$23,457	\$25,722	\$25,729	\$25,729
Research and Development	-Research and Development - Alzheimer's Disease Demonstration Grants to States -Aging network Support Activities	\$46,626	\$52,119	\$41,716	\$41,716
Senior Medicare Patrols & Technical Assistance Centers	Senior Medicare Patrols (HCFAC)	\$1,500	\$2,000	\$3,000	\$3,000
Program Administration	Program Direction	\$17,216	\$18,053	\$17,986	\$17,501
White House Conference on Aging					\$2,842
	Total Budget	\$1,254,442	\$1,351,341	\$1,344,344	\$1,346,701

APPENDIX 6

Partnerships and Coordination

In addition to the fundamental partnerships within the aging network, AoA works closely with many Federal agencies on a wide range of issues.

In the area of nutrition, AoA works with the U.S. Department of Agriculture (USDA) and within HHS, the Office of Public Health and Science on Dietary Reference Intakes (DRIs), formerly known as Recommended Dietary Allowances and on nutrition performance measures related to the Healthy People 2010 Initiative. AoA also participates on such bodies as the Federal Food Safety Coalition chaired within the Food and Drug Administration; the HHS Nutrition Policy Board; the HHS Dietary Guidance committee; the HHS/USDA Food Security committee; and the HHS Dietary Reference Intake Working Group.

In the pursuit of improved transportation services provided through the aging network, AoA works closely with HHS officials and the U.S. Department of Transportation on the Coordinating Council on Access and Mobility to reduce barriers by coordinating approaches to specialized and human services transportation.

AoA is working with the Centers for Disease Control and Prevention (CDC) to expand CDC's Racial and Ethnic Approaches to Community Health (REACH 2010). The purpose of these projects is to eliminate health disparities among older racial and ethnic minority populations. The initiative will target disparities in cardiovascular disease, diabetes, and immunizations among older racial and ethnic minority populations.

In the area of consumer protection and elder abuse, AoA and the Department of Justice (DOJ) are disseminating information on promising Federal, State and local approaches that empower older people to live healthy and safe lives. Featured approaches also address the coordination of public safety, health and social services that provide effective prevention and intervention strategies and reduce victimization. Specific areas of emphasis by AoA and DOJ include: (1) domestic elder abuse; (2) institutional elder abuse; and (3) fraud and exploitation, including consumer fraud issues such as telemarketing. Our shared objective is to foster enhanced collaboration between the justice, health, aging and human services networks.

AoA is developing a partnership with the Health Resources and Services Administration (HRSA) Bureau of Health Professions, Division of Nursing, to initiate a demonstration program to train nurses specifically to work with, educate and mentor caregivers. Although nurses are well trained in acute care for older persons, there is little or no preparatory training for follow-up care and continuing care of chronic conditions.

During FY 2001, AoA played a major role in advancing HHS's initiative to help States implement the Supreme Court's Olmstead decision. AoA joined the Department's internal Olmstead work group comprised of CMS, OCR, ASPE, SAMHSA, and ADD and assisted in developing the Real Choice Systems Change Grants which will provide states with \$70 million dollars to make their systems of long-term care more consumer directed and focused on home and community-based care. As part of this initiative, AoA worked with State units on aging to make sure the interests of the elderly were reflected in state planning efforts related to the System Change Grants. Finally, AoA co-sponsored a national conference on Consumer Direction in Long-Term Care in collaboration with ASPE, CMS, SAMHSA, ADD, and the Robert Wood Johnson Foundation.

FY 2004 Moyer Material

Submitted by the Office of the Assistant Secretary for
Budget, Technology and Finance
U.S. Department of Health and Human Services

March 13, 2003

FY 2004 Moyer Cross-Cutting Material

HHS CROSS-CUTTING TABLES

Acquired Immunodeficiency Syndrome (AIDS)	1
Aging	4
Alzheimer's Disease	6
Cancer	7
Child Care	9
Diabetes And Related Research	10
Family Planning - <i>Services Only</i>	12
Homeless	13
Immunization- <i>Services and Vaccine Purchases Only</i>	15
Minority Health And Assistance- <i>Direct/Specifically Targeted Programs Only</i>	16
Pediatric HIV/AIDS	19
Rural Health	20
Substance Abuse	22
Women's Health	24

HHS SUMMARY TABLES

Requests in the FY 2004 Budget for Which Legislative Authority has Expired or is Due to Expire on September 30, 2003	32
New Programs in the FY 2003 Budget	38
Travel by OPDIV Excluding Reimbursements	39
Entitlement vs. Discretionary and Requests and Appropriation Amounts By OPDIV	40
Funds Available to HHS But Not Appropriated in the L/HHS/E Bill	43
Full-Time Equivalents (FTE) Ceiling, Total FTE, and Total Employment FY 1984-2004	46
Salaries and Expenses Grand Total	47

GOVERNMENT-WIDE TABLES

HIV/AIDS	48
Homeless Programs	50
Drug Abuse	51

OTHER INFORMATION

Centers for Medicare and Medicaid Services-Abortions	52
Total National Expenditures and Numbers Reported for Medicaid Abortions	59

Note: Dollars levels for FY 2003 reflect the FY 2003 column of the FY 2004 President's Budget.

Acquired Immunodeficiency Syndrome (AIDS)			
Program Level			
(Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Food and Drug Administration			
Biologics	\$34,972	\$36,943	\$37,290
Human Drugs	19,601	20,710	20,904
Medical Devices	2,298	2,427	2,450
Other Activities	5,397	5,700	5,754
Field	13,550	14,250	14,384
Total, FDA	\$75,818	\$80,030	\$80,782
Health Resources and Services Administration			
Emergency Relief Grants - Part A - Title I	\$619,381	\$619,514	\$618,881
Care Grant Program - Part B - Title II	977,240	977,373	1,077,027
Early Intervention - Part C - Title III	193,844	194,055	193,981
Grants for Coordinated Services & Access to Research for Women, Infants, Children - Part D - Title IV	70,964	70,990	70,917
AIDS Education and Training Centers - Part F	35,282	35,295	35,259
Dental Services - Part F	13,493	13,498	13,484
Family Planning	2,000	2,000	2,000
Program Management	4,996	4,996	4,996
Total, HRSA	\$1,917,200	\$1,917,721	\$2,016,545
Indian Health Service			
HIV Surveillance	\$1,012	\$1,027	\$1,046
Information & Education/Prevention Services	2,874	2,911	2,953
Total, IHS	\$3,886	\$3,938	\$3,999
Centers for Disease Control and Prevention			
HIV/AIDS Activity	\$931,141	\$933,190	\$932,332
Total, CDC	\$931,141	\$933,190	\$932,332

	FY 2002	FY 2003	FY 2004
National Institutes of Health			
NCI	\$254,252	\$265,009	\$269,615
NHLBI	70,906	75,380	75,524
NIDCR	23,267	24,737	25,357
NIDDK	25,925	29,708	31,024
NINDS	42,166	45,562	47,456
NIAID	1,185,660	1,345,004	1,407,356
NIGMS	48,391	52,385	54,894
NICHD	115,647	125,985	131,133
NEI	12,730	12,777	12,746
NIEHS	8,248	8,589	8,789
NIA	4,985	5,320	5,519
NIAMS	6,302	6,621	6,759
NIDCD	1,737	1,738	1,758
NIMH	163,007	175,996	182,390
NIDA	278,372	303,487	315,011
NIAAA	23,950	25,886	26,944
NINR	10,978	11,877	12,155
NHGRI	6,247	6,641	6,925
NIBIB	972	972	1,062
NCRR	134,791	146,920	153,464
NCCAM	2,552	2,718	2,818
FIC	18,317	21,411	22,740
NLM	6,677	7,177	7,477
OD	53,379	58,040	60,942
Total, NIH	\$2,499,458	\$2,759,940	\$2,869,858
Substance Abuse and Mental Health Services Administration			
<i>Programs of Regional & National Significance</i>			
Mental Health	\$10,503	\$10,560	\$10,583
Substance Abuse Treatment	61,844	62,291	62,291
Substance Abuse Prevention	38,100	38,100	38,100
Substance Abuse Block Grant (Set-aside)	57,987	58,900	60,200
Program Management	600	600	600
Total, SAMHSA	\$169,034	\$170,451	\$171,774
Agency for Healthcare Research and Quality			
Research on Health Costs, Quality, & Outcomes	\$2,913	\$1,400	\$1,800
Total, AHRQ	\$2,913	\$1,400	\$1,800

	FY 2002	FY 2003	FY 2004
Centers for Medicare and Medicaid Services			
Medicaid (Federal Share) ¹	\$4,200,000	\$4,700,000	\$5,200,000
Medicare	2,050,000	2,350,000	2,600,000
Total, CMS	\$6,250,000	\$7,050,000	\$7,800,000
Office of the Secretary			
<i>Office of Public Health and Science:</i>			
Office of Minority Health, GDM	\$12,036	\$10,660	\$10,705
Office on Women's Health	795	1,040	1,040
Office of HIV/AIDS Policy, GDM	919	989	994
AIDS in Minority Communities, GDM	49,991	50,000	50,000
Office for Civil Rights	362	379	374
Total, OS	\$64,103	\$63,068	\$63,113
Global AIDS Trust Fund ²	\$125,000	\$100,000	\$100,000
Prevention of Mother to Child Transmission ³	\$0	\$100,000	\$150,000
TOTAL, AIDS	\$12,038,553	\$13,179,738	\$14,190,203

1 All Medicaid figures represent actuarial estimates.

2 While budgeted in NIH, HHS contributions to the Global Fund to Fight HIV/AIDS, Malaria, and Tuberculosis in FY 2002-2004 are not accounted for in the NIH HIV/AIDS figures, but are accounted for separately. For FY 2002, the figure includes \$25 million transferred from NIH to CDC using the Secretary's transfer authority to be used for the Global Fund.

3 The Prevention of Mother to Child Transmission Initiative is budgeted for in CDC, but is displayed separately in this table.

AGING			
Program Level			
(Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
National Institutes of Health			
NCI	\$140,403	\$153,000	\$158,500
NHLBI	89,736	95,565	97,958
NIDCR	14,353	15,658	16,331
NIDDK	101,000	109,000	113,000
NINDS	160,608	172,975	176,435
NIAID	79,487	81,872	84,328
NICHD	7,696	8,300	8,600
NEI	115,142	124,198	128,690
NIEHS	14,834	16,317	17,133
NIA	890,816	957,626	994,411
NIA MS	53,588	58,140	60,170
NIDCD	15,566	16,763	17,408
NIMH	106,090	114,544	118,809
NIDA	1,981	2,100	2,160
NIAAA	5,475	5,750	5,925
NINR	18,262	18,992	19,732
NHGRI	1,068	1,137	1,180
NIBIB	1,649	4,119	4,296
NCRR	46,272	51,974	54,386
NCCAM	31,878	34,395	35,530
NCMHD	2,129	2,214	2,281
FIC	443	455	465
OD	1,905	3,050	2,200
Total, NIH	\$1,900,381	\$2,048,144	\$2,119,928
Substance Abuse and Mental Health Services			
Administration			
<i>Programs of Regional & National Significance</i>			
Mental Health	\$5,000	\$4,927	\$4,451
Substance Abuse Treatment	0	0	2,000
Total, SAMHSA	\$5,000	\$4,927	\$6,451
Agency for Healthcare Research and Quality			
Medical Expenditures Panel Surveys	\$16,005	\$17,589	\$18,250
Research on Health Costs, Quality & Outcomes	25,266	12,411	13,750
Total, AHRQ	\$41,271	\$30,000	\$32,000

	FY 2003	FY 2004	FY 2004
Administration on Aging			
Aging Service Programs	\$1,351,341	\$1,344,344	\$1,346,701
Total, AoA	\$1,351,341	\$1,344,344	\$1,346,701
Office of the Secretary			
<i>Office of Public Health and Science:</i>			
Office on Women's Health	\$1,671	\$1,700	\$1,700
Total, OS	\$1,671	\$1,700	\$1,700
TOTAL, AGING	\$3,299,664	\$3,429,115	\$3,506,780

ALZHEIMER'S DISEASE

Program Level
(Dollars in Thousands)

	FY 2003	FY 2003	FY 2004
Centers for Disease Control and Prevention			
Chronic Disease Prevention	\$40	\$40	\$40
Total, CDC	\$40	\$40	\$40
National Institutes of Health			
NCI	\$1,030	\$1,100	\$1,150
NHLBI	1,773	1,888	1,935
NINDS	37,618	40,473	41,308
NICHD	2,425	2,600	2,700
NIEHS	5,350	5,885	6,179
NIA	446,936	480,500	498,700
NIAMS	455	500	520
NIDCD	2,573	2,771	2,868
NIMH	69,820	75,384	78,191
NIAAA	431	455	470
NINR	4,464	4,643	4,736
NHGRI	2,330	2,495	2,588
NIBIB	893	956	997
NCRR	14,627	16,609	17,073
NCCAM	3,784	4,080	4,215
NCMHD	68	71	73
FIC	98	100	102
Total, NIH	\$594,675	\$640,510	\$663,806
Agency for Healthcare Research and Quality			
Research on Health Costs, Quality & Outcomes	\$672	\$500	\$700
Total, AHRQ	\$672	\$500	\$700
Centers for Medicare and Medicaid Services			
Medicare	\$673,000	\$709,000	\$739,000
Total, CMS	\$673,000	\$709,000	\$739,000
Administration on Aging			
Alzheimers's Disease Demonstration Program	\$11,496	\$11,500	\$11,500
Total, AoA	\$11,496	\$11,500	\$11,500
TOTAL, ALZHEIMER'S DISEASE	\$1,279,883	\$1,361,550	\$1,415,046

CANCER			
Program Level			
(Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Food and Drug Administration			
Cancer	\$31,508	\$32,538	\$33,130
Breast Cancer MQSA (non-add)	15,590	16,112	16,576
Total, FDA	\$31,508	\$32,538	\$33,130
Centers for Disease Control and Prevention			
Breast and Cervical Cancer	\$191,965	\$200,487	\$211,065
Prostate Cancer	14,062	14,062	13,707
Cancer Registries	40,000	40,000	39,201
Other Chronic Diseases	22,600	22,600	23,592
Infectious Diseases	450	450	450
Environmental Health	3,260	3,260	3,260
Occupational Safety and Health	5,668	5,563	5,563
Total, CDC	\$278,005	\$286,422	\$296,838
Indian Health Service			
Cancer	\$15,352	\$15,352	\$15,352
Breast Cancer (non-add)	13,915	13,915	13,915
Total, IHS	\$15,352	\$15,352	\$15,352
National Institutes of Health			
NCI	\$4,177,830	\$4,608,985	\$4,770,519
NHLBI	60,377	64,302	65,909
NIDCR	44,526	47,735	48,885
NIDDK	65,000	74,300	90,000
NINDS	32,759	35,290	35,996
NIAID	83,937	93,472	96,557
NIGMS	34,991	36,846	38,726
NICHD	10,370	11,200	11,700
NEI	9,739	10,505	10,885
NIEHS	149,767	161,898	167,760
NIA	25,924	27,900	28,900
NIAMS	6,914	7,500	7,760
NIDCD	7,078	7,580	7,671
NIMH	3,870	4,178	4,334
NIDA	2,231	2,410	2,480
NIAAA	1,901	2,000	2,060
NINR	11,805	12,277	12,523
NHGRI	61,025	66,350	68,968
NIBIB	21,288	39,970	41,689
NCRR	75,954	85,589	90,208
NCCAM	14,253	15,370	15,850
NCMHD	16,091	18,987	20,127
FIC	2,385	2,500	2,550
OD	2,666	4,099	2,851
Total, NIH	\$4,922,681	\$5,441,243	\$5,644,907

	FY 2002	FY 2003	FY 2004
Agency for Healthcare Research and Quality			
Research on Health Costs, Quality & Outcomes	\$3,138	\$2,000	\$1,600
Total, AHRQ	\$3,138	\$2,000	\$1,600
Centers for Medicare and Medicaid Services			
Medicaid ¹	\$3,785,000	\$4,175,000	\$4,620,000
Medicare	17,767,000	18,554,000	19,305,000
Total, CMS	\$21,552,000	\$22,729,000	\$23,925,000
Office of the Secretary			
<i>Office of Public Health and Science:</i>			
Office of Minority Health	\$250	\$0	\$0
Office on Women's Health	200	250	250
Total, OS	\$450	\$250	\$250
TOTAL, CANCER	\$26,803,134	\$28,506,805	\$29,917,077

1 All Medicaid figures represent actuarial estimates.

CHILD CARE

Program Level
(Dollars in Thousands)

	FY 2002	FY 2003	FY 2004
Administration for Children and Families¹			
Child Care Entitlement	\$2,717,000	\$2,717,000	\$2,717,000
Child Care & Development Block Grant	2,099,976	2,099,994	2,099,729
Social Services Block Grant	160,000	160,000	160,000
TANF Direct	1,580,000	1,580,000	1,580,000
Funds Transferred to Child Care from TANF	2,000,000	2,000,000	2,000,000
Subtotal, Federal Child Care Funds	\$8,556,976	\$8,556,994	\$8,556,729
Early Learning Opportunities Act Program	24,988	-	-
Social Services Research and Development	283	-	-
Subtotal, Child Care Services	\$25,271	\$0	\$0
Other Sources of Support for Child Care (non-adds)			
"Head Start" ²	\$6,537,640	\$6,667,533	\$6,815,570
Subtotal, Other Support for Child Care Services	\$6,537,640	\$6,667,533	\$6,815,570
TOTAL, CHILD CARE	\$8,582,247	\$8,556,994	\$8,556,729

1 The Community Services Block Grant provides grants through States to local community action agencies for local antipoverty activities, which may include child care. No data on such expenditures is provided to the Federal Government.

2 Data for Head Start are included for informational purposes and are not included in the total. Funding levels include an advance appropriation of \$1.4 billion.

DIABETES AND RELATED RESEARCH			
Program Level (Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Research:			
Food and Drug Administration			
Diabetes	\$3,412	\$3,925	\$4,424
	\$3,412	\$3,925	\$4,424
Centers for Disease Control and Prevention			
Diabetes Core Programs	\$61,683	\$61,480	\$61,350
Prevention Initiative	0	25,000	125,000
Total, CDC	\$61,683	\$86,480	\$186,350
National Institutes of Health			
NCI	\$6,600	\$7,100	\$7,300
NHLBI	70,895	75,503	77,391
NIDCR	5,001	5,328	5,445
NIDDK	427,700	471,700	500,000
NINDS	4,061	4,367	4,454
NIAID	21,007	22,637	23,384
NIAMS	5,613	5,911	6,213
NICHD	30,097	32,400	33,700
NEI	30,795	33,217	34,419
NIHES	1,543	1,668	1,726
NIA	19,815	21,300	22,100
NIMH	2,151	2,322	2,408
NIAAA	387	410	425
NINR	5,704	5,932	6,051
NHGRI	5,707	6,106	6,356
NIBIB	1,291	1,418	1,479
NCRR	43,498	48,468	50,860
NCCAM	1,738	1,875	1,935
NCMHD	7,501	8,889	9,422
OD	2,167	3,910	890
Mandatory Appropriation for Type 1 Diabetes ¹	100,000	100,000	150,000
Total, NIH	\$793,271	\$860,461	\$945,958
Agency for Healthcare Research and Quality			
Research on Health Costs, Quality & Outcomes	\$6,061	\$3,100	\$3,100
Total, AHRQ	\$6,061	\$3,100	\$3,100
Total Research	\$864,427	\$953,960	\$1,011,958

¹ Comparable - All Mandatory Type 1 Diabetes funds are displayed within NIH. CDC utilizes a portion of these funds through intra-agency agreements with NIH.

	FY 2002	FY 2003	FY 2004
Services:			
Health Resources and Services Administration			
Diabetes	\$8,509	\$8,509	\$8,509
Total, HRSA	\$8,509	\$8,509	\$8,509
Indian Health Service			
Model Diabetes	\$7,700	\$7,700	\$7,700
Diabetes Grants	3,000	3,000	3,000
Periodontal Diabetes	300	300	300
Diabetes Funds (mandatory)	100,000	100,000	150,000
Total, IHS	\$111,000	\$111,000	\$161,000
Centers for Medicare and Medicaid Services			
Medicare ²	\$12,180,000	\$12,719,000	\$13,234,000
Total, CMS	\$12,180,000	\$12,719,000	\$13,234,000
Office of the Secretary			
<i>Office of Public Health and Science:</i>			
Office of Minority Health	\$1,929	\$1,831	\$1,831
Office on Women's Health	396	720	720
Total, OS	\$2,325	\$2,551	\$2,551
Total Services	\$12,301,834	\$12,841,060	\$13,406,060
Total, DIABETES AND RELATED RESEARCH	\$13,166,261	\$13,795,026	\$14,545,892

2 The Medicare diabetes cost estimate is the sum of the cost of claims with principal diagnosis of diabetes (direct costs); plus the estimated Medicare costs due to the increase in intensity, complications, volume of services and other factors associated with diabetes (indirect costs).

FAMILY PLANNING - Services Only			
Program Level (Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Health Resources and Services Administration			
Family Planning - Title X	\$264,987	\$265,275	\$264,808
Total, HRS A	\$264,987	\$265,275	\$264,808
Indian Health Service			
Family Planning	\$111,886	\$126,941	\$132,554
Total, IHS	\$111,886	\$126,941	\$132,554
Centers for Medicare and Medicaid Services			
Medicaid ¹	\$760,000	\$810,000	\$870,000
Total, CMS	\$760,000	\$810,000	\$870,000
TOTAL, FAMILY PLANNING - Services Only	\$1,136,873	\$1,202,216	\$1,267,362

¹ FY 2002 data represent actual State expenditures. FY 2003 and FY 2004 figures represent actuarial estimates.

HOMELESS¹ Program Level (Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Targeted Homeless Programs:			
Health Resources and Services Administration			
Consolidated Health Centers	\$108,347	\$120,200	\$131,300
National Health Service Corps Recruitment	0	10,000	0
Total, HRSA	\$108,347	\$130,200	\$131,300
National Institutes of Health			
NICHHD	\$1,389	\$1,500	\$1,600
NIMH	8,532	9,212	9,555
NIDA	10,188	11,000	11,400
NIAAA	1,877	1,975	2,035
NINR	508	528	539
Total, NIH	\$22,494	\$24,215	\$25,129
Substance Abuse and Mental Health Services Administration			
<i>Programs of Regional & National Significance</i>			
Mental Health	\$6,664	\$10,417	\$8,522
Substance Abuse Treatment	20,798	32,235	34,190
PATH	39,855	46,855	50,055
Total, SAMHSA	\$67,317	\$89,507	\$92,767
Agency for Healthcare Research and Quality			
Research on Health Costs, Quality & Outcomes	\$300	\$200	\$200
Total, AHRQ	\$300	\$200	\$200
Administration for Children and Families			
Runaway and Homeless Youth	\$88,024	\$88,133	\$88,043
Education and Prevention for Runaway & Homeless Youth	14,999	14,999	14,999
Head Start	3,200	3,200	3,200
Total, ACF	\$106,223	\$106,332	\$106,242
Office of the Secretary			
Office of Public Health and Science, GDM	\$0	\$175	\$175
Total, OS	\$0	\$175	\$175
Total, Targeted Homeless Programs	\$304,681	\$350,629	\$355,113

¹ The table has been modified to differentiate between funding for programs specifically targeted to the homeless and programs where the homeless are a subset of the total population receiving services.

	FY 2002	FY 2003	FY 2004
Other Programs Providing Services to Homeless:			
Centers for Medicare and Medicaid Services			
Medicaid ²	\$300,000	\$330,000	\$360,000
Total, CMS	\$300,000	\$330,000	\$360,000
Administration for Children and Families			
Head Start ³	\$133,032	\$135,370	\$140,377
Total, ACF	\$133,032	\$135,370	\$140,377
Total, Other Programs Providing Services to Homeless	\$433,032	\$465,370	\$500,377
TOTAL, HOMELESS	\$737,713	\$815,999	\$856,190

2 All Medicaid figures represent actuarial estimates.

3 Information on Head Start spending for homeless is new in the FY 2004 Moyer Material. This information was unavailable in prior submissions.

IMMUNIZATION***Services and Vaccine Purchases Only***

Program Level
(Dollars in Thousands)

	FY 2002	FY 2003	FY 2004
Food and Drug Administration			
Vaccines	\$39,775	\$40,809	\$0
Immunizations - Children's Health	26,800	28,113	28,980
Total, FDA	\$39,775	\$40,809	\$0
Health Resources and Services Administration			
Health Centers	\$1,600	\$1,600	\$1,600
Total, HRSA	\$1,600	\$1,600	\$1,600
Indian Health Service			
Immunization	\$1,526	\$1,556	\$1,580
Total, IHS	\$1,526	\$1,556	\$1,580
Centers for Disease Control and Prevention			
Immunization Activities	\$627,239	\$627,601	\$510,506
Vaccines for Children	989,535	1,056,185	1,145,196
Total, CDC	\$1,616,774	\$1,683,786	\$1,655,702
Centers for Medicare and Medicaid Services			
Medicaid ¹	\$90,000	\$95,000	\$100,000
Medicare	180,000	190,000	200,000
Total, CMS	\$270,000	\$285,000	\$300,000
TOTAL, IMMUNIZATION - Excludes Research Services and Vaccine Purchases Only	\$1,929,675	\$2,012,751	\$1,958,882

¹ All Medicaid figures represent actuarial estimates.

MINORITY HEALTH AND ASSISTANCE <i>Direct/Specifically Targeted Programs Only</i> Program Level (Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Health Resources and Services Administration			
Consolidated Health Centers	\$24,263	\$24,246	\$25,631
Payment to Hawaii	2,044	2,045	2,045
National Health Service Corps Recruitment	10,900	15,700	31,930
Centers of Excellence	32,788	0	0
Health Careers Opportunities Program	34,611	0	0
Loan Repayment/Fellowships for Faculty Services	1,330	0	0
Scholarships for Disadvantaged Students	30,000	6,500	6,400
Nursing Workforce Diversity	6,100	6,100	20,500
Ryan White AIDS:			
Emergency Relief - Part A - Title I	34,000	41,800	41,800
Comprehensive Care -Part B- Title II	7,000	7,000	7,000
Early Intervention - Part C - Title III	44,400	49,400	49,400
Grants for Coordinated Services and Access to Research for Women, Infants, Children - Part D - Title IV	15,700	17,000	17,000
Education and Training Centers - Part F, II(a)	7,700	8,000	8,000
Healthy Start	990	990	987
Total, HRSA	\$251,826	\$178,781	\$210,693
Indian Health Service			
Services	\$2,388,605	\$2,453,835	\$2,502,393
Facilities	369,487	362,571	387,269
Third Party Collections	529,135	554,755	561,720
Quarters	5,700	5,900	5,900
Diabetes (Mandatory)	100,000	100,000	150,000
Total, IHS	\$3,392,927	\$3,477,061	\$3,607,282
Centers for Disease Control and Prevention			
Minority Health Assistance	\$137,439	\$137,186	\$135,912
Total, CDC	\$137,439	\$137,186	\$135,912

	FY 2002	FY 2003	FY 2004
National Institutes of Health ¹			
NCI	\$121,938	\$128,030	\$131,870
NHLBI	241,740	256,000	262,500
NIDCR	19,146	20,752	21,294
NIDDK	133,176	144,000	150,000
NINDS	49,229	53,929	56,955
NIAID	331,298	375,361	392,627
NIGMS	141,691	153,963	153,963
NICHD	277,214	298,600	310,800
NEI	23,165	24,987	25,891
NIHHS	23,367	25,260	26,144
NIA	75,928	81,600	84,700
NIAMS	49,117	53,300	55,225
NIDCD	5,839	6,267	6,504
NIMH	26,708	28,836	29,910
NIDA	74,743	81,000	84,000
NIAAA	35,917	37,713	39,335
NINR	28,089	29,774	30,667
NHGRI	10,781	13,058	13,826
NIBIB	309	1,004	1,047
NCRR	48,666	52,614	55,339
NCCAM	7,380	7,960	8,225
NCMHD	147,242	173,893	180,327
FIC	1,012	1,050	1,065
NLM	8,753	9,559	9,559
OD	5,925	5,909	5,330
Total, NIH	\$1,888,373	\$2,064,419	\$2,137,103

¹ NIH is continuing to refine its definitions of minority health and health disparities research in accordance with Public Law 106-525. Once completed, this will represent a more accurate reporting of resources.

	FY 2002	FY 2003	FY 2004
Substance Abuse and Mental Health Services Administration			
<i>Programs of Regional & National Significance</i>			
Mental Health	\$12,211	\$12,278	\$12,278
Substance Abuse Prevention	38,100	38,100	38,100
Substance Abuse Treatment	71,265	72,382	68,469
Substance Abuse Block Grant	534	547	547
Protection and Advocacy Program	206	206	206
Total, SAMHSA	\$122,316	\$123,513	\$119,600
Agency for Healthcare Research and Quality			
Medical Expenditures Panel Surveys	\$19,400	\$21,300	\$22,000
Total, AHRQ	\$19,400	\$21,300	\$22,000
Centers for Medicare and Medicaid Services			
Research	\$3,181	\$300	\$450
Medicare Quality Improvement Organizations	7,581	8,692	8,795
Legislatively Mandated Demonstrations	1,000	4,000	10,000
Other	5,736	6,470	6,600
Total, CMS	\$17,498	\$19,462	\$25,845
Office of the Secretary			
<i>Office of Public Health and Science:</i>			
Office of Minority Health	\$49,546	\$46,329	\$47,010
Office on Women's Health	1,780	2,475	2,475
AIDS in Minority Communities, GDM	49,991	50,000	50,000
Total, OS	\$101,317	\$98,804	\$99,485
TOTAL, MINORITY HEALTH & ASSISTANCE	\$5,931,096	\$6,120,526	\$6,357,920

PEDIATRIC HIV/AIDS Program Level (Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Health Resources and Services Administration			
<i>Ryan White AIDS:</i>			
Grants for Coordinated Services & Access to Research for			
Women, Infants, Children - Part D - Title IV	\$70,990	\$70,990	\$70,917
Total, HRSA	\$70,990	\$70,990	\$70,917
Centers for Disease Control and Prevention			
HIV/AIDS Activity	\$19,857	\$19,857	\$19,857
Total, CDC	\$19,857	\$19,857	\$19,857
National Institutes of Health			
NCI	\$9,376	\$9,657	\$9,773
NHLBI	4,840	5,145	5,150
NIDCR	1,661	1,712	1,766
NIDDK	1,603	1,519	1,127
NINDS	1,371	1,475	1,506
NIAID	88,829	95,066	99,439
NICHD	89,084	97,000	101,000
NIMH	42,581	45,987	47,643
NIDA	32,786	35,606	36,923
NIAAA	2,385	3,000	3,000
NINR	3,025	3,146	3,209
NCRR	9,001	9,451	9,735
FIC	3,766	3,935	4,015
OD	3,989	4,131	4,338
Total, NIH	\$294,297	\$316,830	\$328,624
Substance Abuse and Mental Health Services Administration			
<i>Programs of Regional & National Significance</i>			
Mental Health	\$1,146	\$960	\$960
Total, SAMHSA	\$1,146	\$960	\$960
Agency for Healthcare Research and Quality			
Research on Health Costs, Quality & Outcomes	\$150	\$90	\$150
Total, AHRQ	\$150	\$90	\$150
TOTAL, PEDIATRIC HIV/AIDS	\$386,440	\$408,727	\$420,508

RURAL HEALTH			
Program Level (Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Health Resources and Services Administration			
Consolidated Health Centers	\$624,200	\$673,400	\$743,600
Black Lung	5,400	5,400	5,400
Rural Health Interdisciplinary Training	6,996	-	-
National Health Service Corps Field	27,700	27,900	27,200
National Health Service Corps Recruitment	59,500	85,800	100,500
Rural Health Outreach Grants	52,098	37,852	37,752
Rural Access to Emergency Devices	12,495	2,000	2,009
Rural Health Policy Development	14,802	6,000	5,984
MCH Block Grant	1,500	1,500	1,500
Poison Control Center	4,200	4,200	4,200
Program Management (J-1 VISA)	-	-	2,500
Rural Hospital Flexibility Grants	39,985	25,000	29,921
State Offices of Rural Health	7,996	4,000	3,990
Denali	20,000	-	-
Telehealth	31,600	4,800	4,800
Total, HRSA	\$908,472	\$877,852	\$969,356
Indian Health Service			
Services	\$2,357,658	\$2,422,307	\$2,470,825
Facilities	369,487	362,571	387,269
Third Party Collections	529,135	554,755	561,720
Quarters	5,700	5,900	5,900
Diabetes (Mandatory)	100,000	100,000	150,000
Total, IHS	\$3,361,980	\$3,445,533	\$3,575,714
Centers for Disease Control and Prevention			
Occupational Safety and Health	\$21,059	\$21,059	\$21,059
Total, CDC	\$21,059	\$21,059	\$21,059

	FY 2002	FY 2003	FY 2004
National Institutes of Health			
NCI	\$41,000	\$44,500	\$46,000
NHLBI	15,388	16,388	16,798
NIDCR	3,255	3,482	3,538
NIAID	299	308	318
NICHHD	4,215	4,500	4,700
NIEHS	14,253	15,407	15,947
NIA	6,308	6,800	7,000
NIAMS	481	520	540
NIMH	30,441	32,867	34,091
NIDA	13,210	14,300	14,900
NIAAA	1,653	1,740	1,795
NINR	8,399	8,735	8,910
NCRR	5,401	6,193	6,792
NCCAM	223	240	245
NCMHD	428	505	535
NLM	6,850	7,482	7,481
OD	44	-	-
Total, NIH	\$151,848	\$163,967	\$169,590
Substance Abuse and Mental Health Services Administration			
<i>Programs of Regional & National Significance</i>			
Mental Health	\$4,091	\$3,047	\$0
Substance Abuse Prevention	39,496	30,563	29,637
Substance Abuse Treatment	33,833	34,088	34,773
Children's Mental Health Services	31,909	31,909	35,909
Protection and Advocacy Program	206	206	206
Total, SAMHSA	\$109,535	\$99,813	\$100,525
Agency for Healthcare Research and Quality			
Research on Health Costs, Quality & Outcomes	\$7,499	\$4,300	\$11,900
Total, AHRQ	\$7,499	\$4,300	\$11,900
Centers for Medicare and Medicaid Services*			
Medicaid ¹	\$205,000	\$220,000	\$235,000
Medicare	140,000	150,000	160,000
Total, CMS	\$345,000	\$370,000	\$395,000
TOTAL, RURAL HEALTH	\$4,905,393	\$4,982,524	\$5,243,144

¹ All Medicaid figures represent actuarial estimates.

* The numbers listed for Medicaid/Medicare solely encompass spending on Rural Health Clinics. The numbers do not include all Medicaid/Medicare programs focused on rural health care, all spending in rural areas, or spending on the State Children's Health Insurance Program.

SUBSTANCE ABUSE			
Program Level (Dollars in Thousands)			
	FY 2002	FY 2003	FY 2004
Health Resources and Services Administration			
Ryan White AIDS Parts A, B, and C	\$43,400	\$43,400	\$43,400
Total, HRSA	\$43,400	\$43,400	\$43,400
Indian Health Service			
Alcohol/Substance Abuse	\$139,005	\$136,849	\$139,975
Total, IHS	\$139,005	\$136,849	\$139,975
Centers for Disease Control and Prevention			
HIV/AIDS Activity	\$123,344	\$123,344	\$123,344
Tobacco Activity	100,973	100,623	100,411
Total, CDC	\$224,317	\$223,967	\$223,755
National Institutes of Health			
NHLBI	\$7,749	\$8,253	\$8,459
NICHD	12,661	13,600	14,200
NIEHS	587	635	657
NIA	1,103	1,180	1,220
NIMH	23,554	25,431	26,378
NIDA	892,082	959,979	995,614
NIAAA	382,838	414,919	430,121
NINR	6,212	6,460	6,590
NCRR	12,053	13,592	14,335
NCCAM	137	140	144
NCMHD	3,579	3,794	3,934
FIC	2,474	2,600	2,650
OD	1,455	844	644
Total, NIH	\$1,346,484	\$1,451,426	\$1,504,946
Substance Abuse and Mental Health Services Administration			
Substance Abuse Treatment	\$2,015,600	\$2,143,000	\$2,341,800
Substance Abuse Prevention	197,500	152,800	148,200
Program Management	91,300	76,800	85,300
Total, SAMHSA	\$2,304,400	\$2,372,600	\$2,575,300

	FY 2002	FY 2003	FY 2004
Centers for Medicare and Medicaid Services			
Medicaid	\$1,570,000	\$1,760,000	\$1,970,000
Medicare	2,370,000	2,500,000	2,630,000
Total, CMS	\$3,940,000	\$4,260,000	\$4,600,000
Administration for Children and Families			
Prevention	\$72,900	\$73,967	\$75,133
Treatment	16,681	16,691	16,691
Total, ACF	\$89,581	\$90,658	\$91,824
Office of the Secretary			
One-time earmarks (underage drinking), GDM	\$499	\$0	\$0
Total, OS	\$499	\$0	\$0
TOTAL, SUBSTANCE ABUSE	\$8,087,686	\$8,578,900	\$9,179,200

HHS WOMEN'S HEALTH ¹		FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Program Level (Dollars in thousands)						
Food and Drug Administration						
Cancer		\$24,317	\$21,739	\$31,508	\$32,538	\$33,130
Breast Cancer (non-add)		24,317	21,739	31,508	32,538	33,130
Cross-cutting Categories		2,178	2,258	2,981	3,025	3,014
Total, FDA		\$26,495	\$23,997	\$34,489	\$35,563	\$36,144
Health Resources and Services Administration						
Infectious Diseases		\$61,472	\$80,900	\$85,900	\$86,000	\$85,900
AIDS/HIV (non-add)		61,472	80,900	85,900	86,000	85,900
Cross-cutting Categories ²		1,158,570	1,307,859	1,456,876	1,537,713	1,628,679
Total, HRSA		\$1,220,042	\$1,388,759	\$1,542,776	\$1,623,713	\$1,714,579
Indian Health Service						
Cancer		\$14,351	\$15,352	\$15,352	\$15,352	\$15,352
Breast Cancer (non-add)		13,915	13,915	13,915	13,915	13,915
Reproductive Health		124,224	128,990	128,990	128,990	128,990
Substance Abuse		1,935	1,981	1,981	1,981	1,981
Cross-cutting Categories		800	800	800	800	800
Total, IHS		\$141,310	\$147,123	\$147,123	\$147,123	\$147,123

¹ Data in this table were prepared using a methodology which reports expenditures according to uniform disease categories, with each category combining direct and indirect expenditures.

² Includes funding for reproductive health, access to primary care services, health professions training, and the HRSA Office of Women's Health.

Centers for Disease Control and Prevention					
	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Cancer	\$180,809	\$213,451	\$226,524	\$235,375	\$245,791
Breast Cancer (non-add)	99,289	110,909	115,672	121,228	127,228
Reproductive Cancers (non-add)	66,440	76,309	81,526	85,166	89,082
Other Cancers: lung, colorectal, neoplasms (non-add)	14,780	26,233	29,326	28,981	29,481
Cardiovascular/Pulmonary	12,681	18,296	19,582	19,321	20,820
Reproductive Health	39,429	53,243	51,902	51,760	51,644
Pregnancy Prevention (non-add)	38,200	52,670	51,377	51,015	50,897
Aging	6,221	6,356	7,269	7,332	7,364
Metabolism/Endocrinology	33,055	37,500	44,895	44,732	44,732
Substance Abuse	51,425	56,431	55,487	55,307	55,307
Behavioral Studies	80,028	83,899	85,000	84,674	84,672
Domestic Violence (non-add)	80,028	83,899	85,000	84,194	84,192
Mental Health	622	474	340	345	346
Infectious Diseases	169,071	185,912	191,390	191,390	191,390
AIDS/HIV (non-add)	54,487	54,232	54,229	54,229	54,229
Neurologic, Muscular & Bone	330	75	-	348	164
Ophthalmic, Otolaryngologic, & Oral	3,591	4,667	6,859	6,796	6,796
Health Effects of the Environment	1,673	2,148	2,621	2,552	2,404
Cross-cutting Categories	115,172	125,091	130,308	129,593	135,093
Total, CDC	\$694,107	\$787,543	\$822,177	\$829,525	\$846,522

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
National Institutes of Health³					
Cancer	\$751,897	\$835,017	\$944,502	\$1,025,807	\$1,061,455
Breast Cancer (non-add)	509,032	552,849	605,781	661,118	684,833
Cardiovascular/Pulmonary	439,926	383,307	325,084	349,326	362,661
Reproductive Health	242,699	278,839	366,455	394,534	408,128
Pregnancy Prevention (non-add)	106,675	127,753	172,290	185,583	191,295
Aging	288,694	318,458	352,021	379,050	391,931
Metabolism/Endocrinology	241,417	277,957	210,991	232,677	246,559
Substance Abuse	133,389	154,099	150,313	161,806	167,793
Behavioral Studies	37,534	33,536	32,150	34,601	35,850
Domestic Violence (non-add)	6,254	6,898	7,980	8,555	8,826
Mental Health	39,934	41,728	38,443	41,475	42,999
Infectious Diseases	273,435	306,987	337,916	372,058	387,639
AIDS/HIV (non-add)	203,119	207,186	226,189	241,172	249,617
Immune Disorders	126,928	182,828	157,786	167,178	170,418
Neurologic, Muscular & Bone	20,249	17,945	32,043	34,446	35,607
Ophthalmic, Otolaryngologic, & Oral	35,326	42,942	50,355	53,486	55,290
Health Effects of the Environment	14,447	21,057	16,612	17,958	18,586
Cross-cutting Categories	23,078	28,440	43,818	47,319	48,424
Total, NIH	\$2,668,953	\$2,923,140	\$3,058,489	\$3,311,721	\$3,433,340

3 Estimates for NIH are exclusive of overlap and will not agree with funding reported for total NIH spending on individual disease areas.

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Substance Abuse and Mental Health Services Administration					
Substance Abuse Prevention	\$378,152	\$379,980	\$445,463	\$413,991	\$418,352
Treatment	71,453	71,048	105,614	66,035	64,077
Behavioral Studies	306,699	308,932	339,849	347,956	354,275
Domestic Violence (non-add)	-	8,080	2,574	-	-
Mental Health	4,000	-	-	-	-
Cross-cutting Categories	565	989	-	-	-
Total, SAMHSA	\$382,717	\$389,049	\$448,037	\$413,991	\$418,352
Agency for Healthcare Research and Quality					
Cancer	\$796	\$433	\$671	\$49	\$0
Breast Cancer (non-add)	796	357	350	49	0
Cardiovascular/Pulmonary	117	74	32	0	0
Reproductive Health	3,215	423	904	281	673
Pregnancy Prevention (non-add)	1,194	258	0	0	0
Aging	818	693	865	782	0
Ophthalmic, Otolaryngologic, & Oral	0	0	0	0	0
Behavioral Studies	1,724	1,606	2,031	839	1,056
Domestic Violence (non-add)	1,560	1,597	2,031	839	1,056
Mental Health	122	25	5	0	0
Neurologic, Muscular & Bone	224	213	0	0	0
Infectious Diseases	2,331	1,725	2,175	784	996
AIDS/HIV (non-add)	625	0	1,019	454	642
Cross-cutting Categories	32,389	38,795	43,219	40,065	42,275
Total, AHRQ	\$41,736	\$43,987	\$49,902	\$42,800	\$45,000

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Centers for Medicare and Medicaid Services⁴					
Cancer	\$7,775,000	\$8,454,000	\$9,124,000	\$9,527,000	\$9,911,000
Breast Cancer (non-add) ⁵	413,000	438,000	508,000	568,000	602,000
Cardiovascular/Pulmonary	32,765,000	35,606,000	38,438,000	40,139,000	41,764,000
Aging	4,699,000	5,169,000	5,580,000	5,827,000	6,063,000
Metabolism/Endocrinology ⁶	2,660,000	2,879,000	3,108,000	3,245,000	3,377,000
Mental Health ⁷	2,819,000	2,938,000	3,442,000	3,486,000	3,623,000
Infectious Diseases	1,410,000	1,505,000	1,624,000	1,696,000	1,765,000
Total, CMS	\$52,128,000	\$56,551,000	\$61,316,000	\$63,920,000	\$66,503,000
Administration for Children and Families					
Behavioral Studies	\$103,075	\$118,994	\$126,616	\$126,616	\$127,423
Domestic Violence (non-add)	1,957	2,157	2,157	2,157	3,000
Total, ACF	\$103,075	\$118,994	\$126,616	\$126,616	\$127,423
Administration on Aging					
Aging	\$5,203	\$7,554	\$7,349	\$7,360	\$7,360
Metabolism/Endocrinology ⁸	486,277	506,396	532,966	534,677	534,677
Behavioral Studies	12,438	105,505	120,441	120,447	120,447
Domestic Violence (non-add)	10,194	11,124	13,423	13,423	13,423
Total, AoA	\$503,918	\$619,455	\$660,756	\$662,484	\$662,484

4 The FY 2000 through 2002 funded amounts were revised to include the actual historical figures for the Fee for Service Expenditures. These expenditures include an adjustment for Medicare and Medicare Plus Choice amounts. FY 2003 and 2004 numbers are projections based on past historical percentages.

5 These amounts reflect estimated Medicare benefit outlays for screening and diagnostic mammograms and the Federal share of Medicaid costs for screening mammograms.

6 The costs of diabetes include direct costs only.

7 Mental Health includes Medicare and Federal Medicaid costs.

8 Includes the FY 2003 transfer of the USDA Nutrition Incentive Services Program to AoA. Transfer is shown comparably in FY 2001 & FY 2002.

Office of the Secretary/Office of Public Health & Science					
	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Cancer	\$134	\$0	\$250	\$0	\$0
Reproductive Health	19,329	24,426	28,924	31,124	31,241
Metabolism/Endocrinology	2	582	0	0	0
Behavioral Studies	1	0	3,032	3,700	3,700
Ophthalmic, Otolaryngologic, & Oral	0	325	250	0	0
Infectious Diseases	4,539	6,167	8,289	7,364	7,364
Cross-cutting Categories ⁹	17,642	23,579	34,721	34,828	34,941
Total, OS/OPHS	\$41,647	\$55,079	\$75,466	\$77,016	\$77,246

9 Reflects the entire budget for the OPHS Office on Women's Health. Includes funds for cardiovascular/pulmonary, osteoporosis/bone health, metabolism/endocrinology, HIV/AIDS and cancer.

Category	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Cancer	\$8,747,304	\$9,539,992	\$10,342,807	\$10,836,121	\$11,266,728
Breast Cancer (non-add)	1,060,349	1,137,769	1,275,226	1,396,848	1,461,106
Cardiovascular/Pulmonary	33,217,724	36,007,677	38,782,698	40,507,647	42,147,481
Reproductive Health	428,896	485,921	577,175	606,689	620,676
Pregnancy Prevention (non-add)	146,069	180,681	223,667	236,598	242,192
Aging	4,999,936	5,502,061	5,947,504	6,221,524	6,469,655
Metabolism/Endocrinology	3,420,751	3,701,435	3,896,852	4,057,086	4,202,968
Substance Abuse	564,901	592,491	653,244	633,085	643,433
Behavioral Studies	234,800	351,620	371,844	370,877	373,148
Domestic Violence (non-add)	99,993	113,755	113,165	109,168	110,497
Mental Health	2,863,678	2,980,227	3,480,788	3,527,820	3,666,345
Infectious Diseases	1,920,848	2,086,691	2,249,670	2,353,596	2,438,289
AIDS/HIV (non-add)	319,703	342,318	367,337	381,855	390,388
Immune Disorders	126,928	182,828	157,786	167,178	170,418
Neurologic, Muscular & Bone	20,803	18,233	32,043	34,794	35,771
Ophthalmic, Otolaryngologic, & Oral	38,917	47,934	57,464	60,282	62,086
Health Effects of the Environment	16,120	23,205	19,233	20,510	20,990
Cross-cutting Categories	1,350,394	1,527,811	1,712,723	1,793,343	1,893,226
Women's Health Total, HHS	\$57,952,000	\$63,048,126	\$68,281,831	\$71,190,552	\$74,011,214

Agency	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
FDA	\$26,495	\$23,997	\$34,489	\$35,563	\$36,144
HRSA	1,220,042	1,388,759	1,542,776	1,623,713	1,714,579
IHS	141,310	147,123	147,123	147,123	147,123
CDC	694,107	787,543	822,177	829,525	846,523
NIH	2,668,953	2,923,140	3,058,489	3,311,721	3,433,340
SAMHSA	382,717	389,049	448,037	413,991	418,352
AHRQ	41,736	43,987	49,902	42,800	45,000
CMS	52,128,000	56,551,000	61,316,000	63,920,000	66,503,000
ACF	103,075	118,994	126,616	126,616	127,423
AoA	503,918	619,455	660,756	662,484	662,484
OS/OPHS	41,647	55,079	75,466	77,016	77,246
Total, HHS	\$57,952,000	\$63,048,126	\$68,281,831	\$71,190,552	\$74,011,214

DEPARTMENT OF HEALTH AND HUMAN SERVICES¹

SUMMARY

Requests in the FY 2004 Budget for Which Legislative Authority has Expired
or is Due to Expire on September 30, 2003

LEGISLATIVE PROGRAM	EXPIRING AUTHORIZATION	AMOUNTS INCLUDED IN THE FY 2004 BUDGET (Dollars in thousands)
HEALTH RESOURCES AND SERVICE ADMINISTRATION		
Native Hawaiian Health Care	P.L. 100-579 as amended by P.L. 102-396	2/
Scholarships for Disadvantaged Students	PHS Act, Section 740(a)	9,900
Advanced Education Nursing	PHS Act, Section 811	26,548
Nursing Workforce Diversity	PHS Act, Section 821	20,564
Organ Transplantation	PHS Act, Sections 371-378	24,924
State Offices of Rural Health	PHS Act, Section 338J	3,990
CENTERS FOR DISEASE CONTROL & PREVENTION		
Birth Defects/Developmental Disabilities/Disabilities and Health	PHS Act, Section 317C	87,462
Chronic Disease Prevention and Health Promotion	PHS Act, Secs. 1706, 1501-1510	834,047
Breast and Cervical Cancer Prevention	PHS Act, Secs. 1501-1510	210,487
Cancer Registries	PHS Act, Section 399F	40,000
Prevention Centers	PHS Act, Section 1706	26,066

¹ Excludes FDA and IHS.

² Included in Health Centers funding.

A PROPOSED OVERPROGRAM		EXPENDING AUTHORIZATION		AMOUNTS INCLUDED IN THE FY 2004 BUDGET (Dollars in Thousands)
CDC Continued				
Epidemic Services and Response		PHS Act, Section 306		76,158
Health Statistics ³		PHS Act, Section 306		124,621
HIV/AIDS, STD, and TB Prevention		PHS Act, Secs. 317E, 318, 318A		1,281,176
Sexually Transmitted Diseases		PHS Act, Section 318, 318A		167,350
Tuberculosis Grants		PHS Act, Section 317E		132,689
Infectious Disease Control		PHS Act, Sec. 318		331,640
Occupational Safety and Health		PHS Act, Section 306		246,329
Preventative Health and Health Services Block Grant		PHS Act, Title XIX, PHS Act, Section 306		134,996
Public Health Improvement		PHS Act, Secs. 318, 319B		113,677
Office of the Director		PHS Act, Secs. 317F, 399F		59,707
NATIONAL INSTITUTE OF HEALTH				10,000
NIH Directors's Discretionary Fund		PHS Act, Sec. 402(f)(3)		
Children's Vaccine Initiative		PHS Act, Sec. 404B(c)	No specific amount requested	
National Research Service Awards		PHS Act, Sec. 487(d)		688,826
NCI Authorization of Appropriations		PHS Act, Sec. 417B(e)		4,724,505
NHLBI Authorization of Appropriations		PHS Act, Sec. 425		2,798,178

³ Included in NHSC funding.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF MANAGEMENT AND BUDGET FISCAL YEAR 2004 (Subitem in Third Page)			DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF MANAGEMENT AND BUDGET FISCAL YEAR 2004 (Subitem in Third Page)	
NIH Continued				
Aging Processes Regarding Women	PHS Act, Sec. 445H	No specific amount requested		971,709
NIA Authorization of Appropriations	PHS Act, Sec. 445I PHS Act, Sec. 447A(b) (expired 1998)	No specific amount requested		
Potential Environmental and Other Risks Contributing to Incidence of Breast Cancer	PHS Act, Sec. 191(d)	No specific amount requested		
Conception and Infertility Research Centers (NICHD)	PHS Act, Sec. 452A(g)	No specific amount requested		1,359,008
NIMH Authorization of Appropriations	PHS Act, Sec. 464R(f)			967,898
NIDA Authorization of Appropriations	PHS Act, Sec. 464L(d)			
Medical Development Program	PHS Act, Sec. 464P(e)	No specific amount requested		418,487
NIAAA Authorization of Appropriations	PHS Act, Sec. 464H(d)			315,163
NLM Authorization of Appropriations	PHS Act, Sec. 468(a)	No specific amount requested		
Community-based AIDS Clinical Trials	PHS Act, Sec. 2313(e)	No specific amount requested		
Model Protocols for Clinical Care of Infected Individuals	PHS Act, Sec. 2318(e)	No specific amount requested		2,769,997
Comprehensive Plan for Expenditure of AIDS Appropriations	PHS Act, Sec. 2353			10,000
Emergency AIDS Discretionary Fund	PHS Act, Sec. 2356(g)(1)			
Prostate Cancer	PHS Act, Sec. 417B(c) (expired 1996)	No specific amount requested		1,500
AIDS Loan Repayment Program	PHS Act, Sec. 487A(c) (expires in mid 2001)			
Parkinson Disease	PHS Act, Sec. 409B(e) (expired 2000)	No specific amount requested		

PROPOSED BUDGET SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION		AMOUNTS INCLUDED IN BUDGET FOR FISCAL YEAR 2006 (Details in 100 series)
All programs authorized by the Child Health Act of 2000	PHS Act, Sec. 501-581	\$1,042,508
Community Mental Health Services Performance Partnership Grants	PHS Act, Sec. 1920 (a)	433,000
Substance Abuse Prevention & Treatment Performance Partnership Grants	PHS Act, Sec. 1953 (a)	1,785,000
Data Infrastructure Development	PHS Act, Sec. 1971	11,000
Protection & Advocacy for Individuals with Mental Illness Act	P.L. 99-319, Sec. 117	32,500
ADMINISTRATION FOR CHILDREN AND FAMILIES		
Head Start	Sec. 639 of the Head Start Act.	\$6,870,000
Consolidated Runaway and Homeless Youth Program	Sec. 388(a)(1) of the Runaway and Homeless Youth Act.	99,633
Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth	Sec. 388 of Part E of the Runaway and Homeless Youth Act.	14,999
Community-Based Family Resource and Support Grants	Sec. 210 of the Child Abuse Prevention and Treatment Act.	33,403
Adoption Incentive Program	Sec. 473A of the Social Security Act.	43,000
Community Services Block Grant	Sec. 674(a) of the Community Services Block Grant Act	494,967
Community Services Discretionary Activities	Sec. 680 of the Community Services Block Grant Act.	26,939
Community Food & Nutrition	Sec. 681(d) of Community Services Block Grant Act.	0
Individual Development Accounts	Sec. 416 of the Assets for Independence Act.	24,912

ACF Continued			0
National Youth Sports	Sec. 682 of Community Services Block Grant Act.		16,488,667
Temporary Assistance for Needy Families	Sec. 403 of the Social Security Act.		2,000,000
TANF Contingency Fund	Sec. 403(b) of the Social Security Act.		319,450
TANF Supplemental Grants	Sec. 403(e) of the Social Security Act.		45,119
Native American Programs	Sec. 803 and 816 of the Native American Programs Act.		7,633
Native Employment Works	Sec. 412(a)(2) of the Social Security Act.		417,626
Refugee and Entrant Assistance	Sec. 414(e) of Title IV of the Immigration and Nationality Act and Sec. 501 of Title V of the Refugee Education Assistance Act of 1980.		
Victims of Torture	Sec. 5 of the Torture Victims Relief Act of 1998.		10,000
Matching Grants to Territories	Sec. 1108 of the Social Security Act.		15,000
High Performance Bonus	Sec. 404A of the Social Security Act.		100,000
Native Employment Works	Sec. 412(a)(2) of the Social Security Act.		7,633
Child Welfare Study	Sec. 429A of the Social Security Act.		0
Welfare Research	Sec. 413(h) of the Social Security Act.		15,000
Child Abuse State Grants	Sec. 112 of the Child Abuse Prevention and Treatment.		22,013
Child Abuse Discretionary Activities	Sec. 112 of the Child Abuse Prevention and Treatment.		26,301

APPROPRIATION PURPOSE		EXPIRING AUTHORIZATION		AMOUNTS INCLUDED IN FISCAL YEAR 2004 BUDGET (Dollars in thousands)	
ACF Continued					
Abandoned Infants Assistance		Sec. 104 of the Abandoned Infants Assistance Program (42 USC 670 note).		12,086	
Adoption Opportunities		Sec. 205 of CAPTA.		27,343	
Child Care and Development Block Grant		Sec. 658B, Child Care Development Block Grant Act.		2,099,994	
Child Care Entitlement		Sec. 418 of the Social Security Act		2,717,000	
Refugee Resettlement		Sec. 414 of the Immigration and Nationality Act		2,717,000	
Trafficking Victims Protection		Section. 107(b)(1) of the Victims of Trafficking and Violence Protection Act		10,000	
ADMINISTRATION ON AGING					
Alzheimer's Disease Demonstration Grants to States		Public Health Services Act, Sec. 398		11,500	
Aging Services Programs/ Innovation Grants		Older Americans Act, Section 375		0	
Aging Services Programs/ Activities of National Significance		Older Americans Act, Section 376		0	
OFFICE OF THE SECRETARY					
GENERAL DEPARTMENTAL MANAGEMENT:					
Office of Public Health and Science		PHS Act, Title XX, Section 2001 (expired 9/30/85)		31,241	
A dolescent Family Life		PHS Act, Section 1707 (expired 9/30/02)		47,010	
Office of Minority Health		PHS Act, Section 1701(b) (expired 9/30/02)		7,620	
Office of Disease Prevention and Health Promotion					

DEPARTMENT OF HEALTH AND HUMAN SERVICES SUMMARY New Programs in the FY 2004 Budget	
APPROPRIATION/PROGRAM	FY 2004 BUDGET REQUEST (Dollars in Thousands)
NATIONAL INSTITUTES OF HEALTH	
Intramural research in the National Institute of Biomedical Imaging and Bioengineering	\$3,000
SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION	
Drug Treatment Vouchers	\$200,000
ADMINISTRATION FOR CHILDREN AND FAMILIES	
Independent Living Vouchers	\$60,000
Mentoring Children of Prisoners	\$50,000
Promotion & Support of Responsible Fatherhood & Healthy Marriage	\$20,000
Children's Welfare Research	\$15,000
Maternity Group Home	\$10,000
Unaccompanied Alien Children	\$34,000
ADMINISTRATION ON AGING	
Aging Services Program/White House Conference on Aging	\$2,842
OFFICE OF THE SECRETARY:¹	
Transformation of the Commissioned Corps, GDM	\$5,000
Afghanistan, GDM	\$5,000
Pandemic Flu, PHSSEF	\$100,000

¹ Does not include the Office for Civil Rights or the Office of the Inspector General.

DEPARTMENT OF HEALTH AND HUMAN SERVICES¹

SUMMARY

Travel by OPDIV Excluding Reimbursements

(Dollars in Thousands)

OPERATING DIVISION (OPDIV)	FY 2002	FY 2003	FY 2004
Health Resources and Services Administration	\$3,973	\$3,938	\$3,935
Centers for Disease Control and Prevention	35,465	35,239	36,535
National Institutes of Health	43,860	50,344	52,154
Substance Abuse and Mental Health Administration	1,906	2,200	2,200
Agency for Healthcare Research and Quality	521	766	580
Centers for Medicare and Medicaid Services	9,800	9,000	10,200
Administration for Children and Families	4,039	3,932	3,988
Administration on Aging	334	457	464
Office of the Secretary	4,885	4,885	4,846
Public Health and Social Services Emergency Fund	4,151	3,492	3,492
TOTAL, HHS	\$108,934	\$114,253	\$118,394

¹ Excludes FDA and IHS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES¹
SUMMARY
Entitlement vs. Discretionary and
Requests and Appropriation Amounts By OPDIV²
(Dollars in Thousands)

	Entitlement	Discretionary	Total
HEALTH RESOURCES AND SERVICE			
FY 2002 Request	174,855	5,009,471	5,184,326
FY 2002 Appropriation	137,000	6,115,429	6,252,429
FY 2003 Request	142,000	5,415,867	5,557,867
FY 2004 Request	138,000	5,672,376	5,810,376
CENTERS FOR DISEASE CONTROL AND PREVENTION			
FY 2002 Request	0	3,696,611	3,696,611
FY 2002 Appropriation	0	4,313,591	4,313,591
FY 2003 Request	0	4,046,315	4,046,315
FY 2004 Request	0	4,157,330	4,157,330
NATIONAL INSTITUTES OF HEALTH			
FY 2002 Request	0	23,041,902	23,041,902
FY 2002 Appropriation	0	23,118,657	23,118,657
FY 2003 Request	0	27,167,643	27,167,643
FY 2004 Request	0	27,663,991	27,663,991

¹ Excludes ERF Funding, FDA, IHS and Retirement Pay and Medical Benefits for PHS Commissioned Officers accounts. Excludes ATSDR appropriation for CDC, and VA-HUD appropriation for NIEHS. FY 2002 and FY 2003 reflect actual requests and appropriations and accordingly, are not comparable with the FY 2004 Request.

² Levels reflect the appropriated amounts net transfers, supplementals, rescissions and reductions.

	Entitlement	Discretionary	Total
SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION			
FY 2002 Request	0	3,029,456	3,029,456
FY 2002 Appropriation	0	3,135,709	3,135,709
FY 2003 Request	0	3,194,696	3,194,696
FY 2004 Request	0	3,393,315	3,393,315
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY			
FY 2002 Request	0	306,245	306,245
FY 2002 Appropriation	0	298,730	298,730
FY 2003 Request	0	250,000	250,000
FY 2004 Request	0	279,000	279,000
CENTERS FOR MEDICARE AND MEDICAID SERVICES			
FY 2002 Request	224,953,633	2,351,158	227,304,791
FY 2002 Appropriation	229,319,539	2,432,771	231,752,310
FY 2003 Request	240,154,855	2,513,628	242,668,483
FY 2004 Request	271,837,683	2,733,507	274,571,190
ADMINISTRATION FOR CHILDREN AND FAMILIES			
FY 2002 Request	31,791,975	12,863,609	44,655,584
FY 2002 Appropriation	34,193,577	13,056,950	47,250,527
FY 2003 Request	34,313,595	13,047,172	47,360,767
FY 2004 Request	33,540,176	13,448,715	46,988,891

	Entitlement	Discretionary	Total
ADMINISTRATION ON AGING			
FY 2002 Request	0	1,097,718	1,097,718
FY 2002 Appropriation	0	1,199,671	1,199,671
FY 2003 Request	0	1,341,344	1,341,344
FY 2004 Request	0	1,343,701	1,343,701
OFFICE OF THE SECRETARY			
FY 2002 Request	0	422,790	422,790
FY 2002 Appropriation	0	415,745	415,745
FY 2003 Request	0	432,490	432,490
FY 2004 Request	0	430,197	430,197
PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND			
FY 2002 Request	0	250,619	250,619
FY 2002 Appropriation	0	242,643	242,643
FY 2003 Request	0	2,374,980	2,374,980
FY 2004 Request	0	1,896,149	1,896,149

3 FY 2003 & 2004 amounts include the Nutrition Services Incentive Program as a line item in AoA's request.

DEPARTMENT OF HEALTH AND HUMAN SERVICES ¹ SUMMARY Funds Available to HHS But Not Appropriated in the L/HHS/E Bill (Dollars in Thousands)									
APPROPRIATION/PROGRAM	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008		
HEALTH RESOURCES AND SERVICES ADMINISTRATION									
Abstinence Education Block Grant	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000		
CENTERS FOR DISEASE CONTROL AND PREVENTION									
Mandatory Appropriation for Type 1 Diabetes	\$78,203	\$77,388	\$73,467						
EPA Superfund Allocations to ATSDR	\$12,000								
Emergency Response Fund									
NATIONAL INSTITUTES OF HEALTH									
ONDCP Transfers	6,880								
Mandatory Appropriation for Type 1 Diabetes ²	100,000	100,000	150,000	150,000	150,000	150,000	150,000		
Breast Cancer Stamp Funds	3,595	1,716							
Superfund Research Activities	70,225	75,774	78,774						
Emergency Response Fund (For Superfund Research)	10,500								
CENTERS FOR MEDICARE AND MEDICAID SERVICES									
Title XI and XVIII of the Social Security Act, As Amended:									
Medicare Quality Improvement Organizations ³	\$382,788	\$716,100	\$99,600	\$348,300	\$765,600	\$106,600	\$375,000		
Ticket to Work & Work Incentives Act of 1999 (P.L. 106-170)	\$67,000	\$72,000	\$77,000	\$81,000	\$81,840	\$41,698	\$42,615		

¹ Excludes FDA and IHS, and any OPDIVs who do not receive funding from sources other than the L/HHS/E Bill.

² Comparable - All Mandatory Type 1 Diabetes funding displayed within NIH. CDC utilizes a portion of these funds through intra-agency agreements with NIH.

³ Formerly known as Peer Review Organizations or PROs. The funding levels for FY 2002 and FY 2003 reflect apportioned amounts for the Medicare Quality Improvement Organizations (QIOs). Funding levels after FY 2003 have not yet been apportioned by the Office of Management and Budget. After FY 2003, therefore, the dollar amounts represent only preliminary estimates of obligations included in the President's FY 2004 budget. The variation in dollar amounts from one fiscal year to another reflects the three year contract cycle of the QIOs.

APPROPRIATION/PROGRAM	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
CMS Continued							
Trade Act of 2002, Title II (P.L. 107-210):							
Qualified High-Risk Pools	\$0	\$60,000	\$40,000	\$0	\$0	\$0	\$0
Health Insurance Portability and Accountability Act of 1996 (P.L. 104-91):							
Medicare Integrity Program	700,000	720,000	720,000	720,000	720,000	720,000	720,000
HCFAC ⁴	2,675	22,000	To be det.	To be det.	To be det.	To be det.	
Balanced Budget Act of 1997 (P. L. 105-33):							
State Children's Health Insurance Program	3,115,200	3,175,200	3,175,200	4,082,400	4,082,400	5,040,000	5,040,000
Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) State Grants and Demonstrations	67,000	72,000	77,000	81,000	82,000	42,000	43,000
ADMINISTRATION FOR CHILDREN AND FAMILIES							
Temporary Assistance to Needy Families (TANF)							
State Family Assistance Grant	16,488,667	16,488,667	16,488,667	16,488,667	16,488,667	16,488,667	16,488,667
Territories-Family Assistance Grants	77,875	77,875	77,875	77,875	77,875	77,875	77,875
Matching Grants to Territories	15,000	15,000	15,000	15,000	15,000	15,000	15,000
Supplemental Grants for Population Increase	319,450	319,450	319,450	319,450	319,450	319,450	319,450
Bonus: Reduction in Out-of-Wedlock Births	100,000	0	0	0	0	0	0
Technical Assistance & Welfare Research-Family Formation	0	[100,000]	100,000	100,000	100,000	100,000	100,000
Family Formation Grant	0	100,000	100,000	100,000	100,000	100,000	100,000
Bonus to Reward High Performance (non-add)	[200,000]	[300,000]	500,000	[100,000]	[100,000]	[100,000]	[100,000]
Tribal Work Program	7,633	7,633	7,633	7,633	7,633	7,633	7,633
Total, TANF	17,008,625	17,008,625	17,108,625	17,108,625	17,108,625	17,108,625	17,108,625

4 FY 2003 HCFAC funding levels are preliminary estimates. The Secretary and the Attorney General will negotiate the final amounts.

APPROPRIATION PROGRAM		FY 2002	FY 2003	FY 2005	FY 2006	FY 2007	FY 2008
AC-Continued							
Contingency Fund		\$1,958,000	\$2,000,000	\$0	\$0	\$0	\$2,000,000
Children's Research and Technical Assistance							
Training and Technical Assistance		12,318	11,790	11,670	11,950	12,310	12,680
Federal Parent Location Service		24,609	23,580	23,120	23,900	24,620	25,360
Welfare Research		0	15,000	15,000	15,000	15,000	15,000
<i>Total, Children's Research and Technical Assistance</i>		36,927	50,370	50,010	50,850	51,930	53,040
Child Care Entitlement							
Mandatory		1,177,525	1,177,525	1,177,525	1,177,525	1,177,525	1,177,525
Matching		1,519,343	1,478,343	1,478,343	1,478,343	1,478,343	1,478,343
Training & Technical Assistance		6,792	6,792	6,792	6,792	6,792	6,792
Tribal Mandatory Funds		54,340	54,340	54,340	54,340	54,340	54,340
<i>Total, Child Care Entitlement</i>		2,758,000	2,717,000	2,717,000	2,717,000	2,717,000	2,717,000
Targeted Assistance (P.L. 104-193)		21,761,552	21,775,995	19,875,635	19,876,475	19,877,555	21,878,665
Children's Justice Grants to States (PL 99-401)		17,000	17,000	17,000	17,000	17,000	17,000
ADMINISTRATION ON AGING							
HCFAC (P.L. 104-191) ⁵		2,000	3,000	TBD	TBD	TBD	TBD
OFFICE OF THE SECRETARY							
Health Care Fraud and Abuse Control (P.L. 104-191) ⁵							
Office of the General Counsel		4,180	4,896	TBD	TBD	TBD	TBD
Office of the Inspector General		145,000	160,000	160,000	160,000	TBD	TBD
Assistant Secretary for Budget, Technology and Finance							
Foreign Assistance Act		125	0	0	0	0	0
		9,000	TBD	TBD	TBD	TBD	TBD
PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND							
Bioterrorism Funding (P.L. 107-117)		2,644,314	0	0	0	0	0

TBD - To Be Determined.

⁵ FY 2003 HCFAC funding levels are preliminary estimates. The Secretary and the Attorney General will negotiate the final amounts.

DEPARTMENT OF HEALTH AND HUMAN SERVICES¹

SUMMARY

Full-Time Equivalents (FTE) Ceiling, Total FTE, and Total Employment
FY 1984-2004

	1984	1985	1986	1987	1988	1989	1990
FTE Ceiling	134,496	128,215	123,745	118,745	113,837	114,762	114,032
Total FTE (End-of-Year)	135,464	129,565	124,924	119,755	117,152	115,981	115,619
Total Employment (End-of-Year)	130,544	124,527	118,520	114,968	114,410	113,689	115,911
	1991	1992	1993	1994	1995	1996	1997
FTE Ceiling	102,025	104,879	104,256	103,570	36,314	36,388	33,757
Total FTE (End-of-Year)	99,172	102,573	103,883	102,546	34,256	33,734	33,680
Total Employment (End-of-Year)	104,148	104,214	103,071	100,689	33,847	34,443	34,207
	1998	1999	2000	2001	2002	2003	2004
FTE Ceiling	34,251	35,248	37,951	39,498	40,097	40,068	39,663
Total FTE (End-of-Year)	34,464	35,434	36,929	38,102	39,079	40,068	39,663
Total Employment (End-of-Year)	35,923	37,305	38,527	40,019	40,759	40,068	39,663

1 Excludes FDA and IHS. FY 2003 and FY 2004 data reflect budgeted FTE and estimated employment levels. The Social Security Administration became an independent agency in FY 1995 and is not included in FY 1995 and beyond. Commissioned Officers detailed to other Federal agencies are not included in totals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES ¹				
SUMMARY				
SALARIES AND EXPENSES GRAND TOTAL				
(Dollars in Thousands)				
	FY 2002	FY 2003	FY 2004	
11.1 Full-time permanent	\$1,693,384	\$1,802,950	\$1,843,593	
11.3 Other than full-time permanent	332,318	355,620	367,158	
11.5 Other personnel compensation	66,987	69,941	70,927	
11.7 Military personnel	109,937	123,165	125,954	
11.8 Special Personnel Services	117,847	131,376	134,331	
11.9 Total personnel compensation	2,320,473	2,483,052	2,541,963	
12.1 Civilian personnel benefits	504,102	541,939	556,102	
12.2 Military personnel benefits	62,369	71,442	75,566	
13.0 Benefits for former personnel	2,598	2,759	2,758	
21.0 Travel	110,351	116,271	119,411	
22.0 Transportation of things	16,460	14,612	15,198	
23.2 Rental payments to others	30,107	31,597	32,675	
23.3 Communications, utilities, and miscellaneous charges	101,862	97,935	92,403	
24.0 Printing and reproduction	53,308	42,687	43,425	
25.1 Consulting Services	315,556	308,452	313,100	
25.2 Other Services	4,219,354	4,461,433	4,650,754	
26.0 Supplies and Materials	287,110	338,947	346,800	
Total HHS Salaries & Expenses	\$ 8,023,650	\$ 8,511,126	\$ 8,790,155	

¹ Excludes FDA, IHS, ATSDR, and NIEHS Superfund Activities; Administrative costs for NIH were calculated using HHS' traditional method.

HIV/AIDS			
Program Level			
2002-2004			
(Dollars in Millions)			
	2002	2003	2004
HHS:			
HHS Discretionary	\$5,789	\$6,130	\$6,390
Medicaid (Federal Share)	4,200	4,700	5,200
Medicare	2,050	2,350	2,600
Sub-Total, HHS	\$12,039	\$13,180	\$14,190
All Other Government			
Social Security - DI	\$961	\$985	\$1,014
Social Security - SSI	390	410	430
Veterans Affairs Department	391	396	402
Defense Department	96	78	88
Agency for International Development	510	740	790
Justice/Bureau of Prisons	16	17	19
State Department	0	0	450
Labor Department	11	1	1
Education Department	0	0	0
Housing and Urban Development	277	292	297
Ofc. Personnel Mgmt. - FEHB	297	321	343
Sub-Total, All Other Government	\$2,949	\$3,240	\$3,834
TOTAL, HIV/AIDS	\$14,988	\$16,420	\$18,024

HIV/AIDS

Program Level
1989 - 2000

(Dollars in Millions)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
HHS:												
HHS Discretionary	\$1,592	\$1,891	\$1,967	\$2,079	\$2,569	\$2,700	\$2,898	\$3,267	\$3,537	\$4,094	\$4,546	\$5,226
Medicaid (Federal Share)	670	870	800	1,000	1,300	1,500	1,800	2,200	2,600	2,900	3,300	3,700
Medicare	110	180	400	600	800	1,000	1,100	1,300	1,400	1,500	1,700	1,900
Ricky Ray Hemophilia Relief Fund	--	--	--	--	--	--	--	--	--	--	75	580
Sub-Total, HHS	\$2,372	\$2,941	\$3,167	\$3,679	\$4,669	\$5,200	\$5,798	\$6,767	\$7,537	\$8,494	\$9,621	\$11,406
All Other Government												
Social Security - DI	\$184	\$266	\$372	\$481	\$568	\$631	\$684	\$738	\$787	\$828	\$870	\$919
Social Security - SSI	55	95	150	200	250	250	250	275	305	330	370	340
Veterans Affairs Department	220	258	279	299	312	317	331	350	378	401	345	405
Defense Department	124	127	125	155	127	110	98	84	95	86	97	108
Agency for International Development	71	78	94	117	115	120	115	117	121	139	200	430
Justice/Bureau of Prisons	5	5	5	5	6	6	6	7	7	7	8	15
State Department	1	1	1	1	1	1	--	--	--	--	--	--
Labor Department	1	1	1	1	1	1	1	2	2	2	2	11
Education Department	--	--	--	--	--	--	--	--	--	1	1	1
Housing and Urban Development	--	--	48	100	156	171	171	196	204	225	232	257
Ofc. Personnel Mgmt. - FEHB	37	61	103	175	193	212	226	241	253	266	279	292
Sub-Total, All Other Gov't	\$698	\$892	\$1,178	\$1,534	\$1,729	\$1,819	\$1,882	\$2,010	\$2,152	\$2,285	\$2,404	\$2,778

HOMELESS PROGRAMS											
Program Level											
(Dollars in Thousands)											
	1997	1998	1999	2000	2001	2002	2003	2004			
Department of Health and Human Services											
Administration for Children and Families	\$75,022	\$76,669	\$76,802	\$82,344	\$87,322	\$239,255	\$241,702	\$246,619			
Agency for Healthcare Research and Quality	400	50	0	0	161	300	200	200			
Centers for Medicare and Medicaid Services	185,000	205,000	225,000	245,000	270,000	300,000	330,000	360,000			
Health Resources & Services Administration	69,345	71,309	79,962	82,401	95,060	108,347	130,200	131,300			
National Institutes of Health	16,031	15,477	12,179	14,667	17,520	22,494	24,215	25,129			
Substance Abuse & Mental Health Services Administration	45,361	33,228	39,447	46,980	60,576	67,317	89,507	92,767			
Office of the Secretary	0	0	0	0	150	0	175	175			
Sub-Total, HHS	\$391,159	\$401,733	\$433,390	\$471,392	\$530,789	\$737,713	\$815,999	\$856,190			
All Other Government											
Department of Agriculture	\$170,000	\$145,000	\$135,000	\$143,000	\$145,000	\$150,000	\$190,000	\$190,000			
Department of Education	25,000	28,800	28,800	28,800	35,000	50,000	50,000	50,000			
Department of Housing and Urban Development	823,000	823,000	975,000	1,020,000	1,023,000	1,123,000	1,283,000	1,528,000			
Department of Labor	0	3,000	3,000	9,600	17,500	18,300	17,500	19,000			
Department of Veterans Affairs	83,900	336,700	363,300	407,000	389,700	394,400	406,600	473,400			
Federal Emergency Management Administration ¹	100,000	100,000	100,000	110,000	139,700	140,000	0	0			
Interagency Council on the Homeless ²	0	0	0	0	[500,000]	[500,000]	[1,000,000]	[1,500,000]			
Sub-Total, All Other Gov't	\$1,201,900	\$1,436,500	\$1,605,100	\$1,718,400	\$1,749,900	\$1,875,700	\$1,947,100	\$2,260,400			
TOTAL, HOMELESS PROGRAMS	\$1,593,059	\$1,838,233	\$2,038,490	\$2,189,792	\$2,280,689	\$2,613,413	\$2,763,099	\$3,116,590			

1 In FY 2003 FEMA homeless funding transferred to HUD.

2 Shown as non-add. Funded in HUD.

DRUG ABUSE ¹			
Budget Authority			
(Dollars in Millions)			
	FY 2002	FY 2003	FY 2004
Department of Defense ²	\$852.60	\$871.90	\$817.40
Department of Education	669.3	634.3	584.3
Dept. of Health & Human Services			
National Institute on Drug Abuse	885.2	960	995.6
Substance Abuse and Mental Health Services Administration	2,304.40	2,372.60	2,575.30
Total, HHS	3,189.60	3,332.60	3,570.90
Department of Homeland Security			
Border and Transportation Security ³	1,183.60	1,271.80	1,372.90
U.S. Coast Guard	609.7	596.1	669.1
Total, DHS	1,793.30	1,867.90	2,041.90
Department of Justice			
Bureau of Prisons	39.4	43.5	45.2
Drug Enforcement Administration	1,562.50	1,659.60	1,677.30
Interagency Crime and Drug Enforcement ⁴	446.5	470.3	541.8
Office of Justice Programs	893.2	286.7	301.5
Total, DOJ	2,941.50	2,460.10	2,565.80
ONDCP			
Operations	25.2	25.5	27.3
High Intensity Drug Trafficking Area Program	221.3	206.4	206.4
Counterdrug Technology Assessment Center	42.3	40	40
Other Federal Drug Control Programs	239.3	251.3	250
Total, ONDCP	528.1	523.1	523.6
Department of State			
Bureau of International Narcotics and Law Enforcement Affairs	871.9	877.5	876.9
Department of Veterans Affairs			
Veterans Health Administration	635.7	663.7	690.5
Other Presidential Initiatives ⁵	3	8	8
Total, Federal Drug Budget	\$11,485.00	\$11,239.00	\$11,679.30

¹ Due to the change in ONDCP's reporting of the Federal Drug Budget, totals for HHS in this table do not match levels reported in the HHS Substance Abuse table on page 22.

² The FY 2003 funding level for the Department of Defense reflects enacted appropriations.

³ Drug Control components displayed include the U.S. Customs Service and the Border Patrol.

⁴ The FY 2004 Budget proposes the merger of the Treasury ICDE account into Justice's ICDE account. This merger is reflected retrospectively.

⁵ This includes \$5 million for the Corporation for National Service's Parents Drug Corps beginning in FY 2003 and \$3 million for SBA's Drug-Free Workplace programs for all three fiscal years.

Centers for Medicare and Medicaid Services

ABORTIONSPart I - Background

HHS Appropriations Acts have contained restrictions on the Departments funding of abortions since the Appropriations Act for FY 1977. HHS was enjoined by a Federal District Court from enforcing the FY 1977 restrictions until August 4, 1977. Consequently, the Department provided funding for all abortions which were covered under a States plan that were performed through that date. The appropriations restrictions, commonly known as the Hyde Amendment restrictions, have governed HHS's funding of all abortions performed after August 4, 1977, except for those abortions performed during the period February 19 through September 19, 1980. Federal funding was available for all medically necessary abortions performed during that period under the criteria set forth by the District Court for the Eastern District of New York and described in Harris v. McRae, 448 U.S. 297 (1980).

The following excerpts from instructions issued by HHS set forth the rules under which the Department has funded abortions performed after August 4, 1977, with its appropriations for FY 1977 through FY 1980.

1. For abortions performed after August 4, 1977, and for which funds appropriated by the Appropriations Act for FY 1977 or the continuing resolutions which appropriated funds through December 1, 1977, are used to pay the claim:

where the attending physician, based on his or her professional judgment, has certified in writing that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term;

2. For abortions performed after August 4, 1977, and prior to February 14, 1978, and for which funds appropriated by P.L. 95-205 (Appropriations Act for FY 1978) or P.L. 95-480 (Appropriations Act for FY 1979) are used to pay the claim:

- (a) where the attending physician, based on his or her professional judgment, has certified in writing that the abortion is necessary because the life of the mother would be endangered if the fetus were carried to term;
- (b) where two physicians, based on their professional judgment, have certified in writing that severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term or
- (c) for the victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service.

The Department will accept any reasonable interpretation of those provisions for abortions covered under paragraph 2.

3. For abortions performed on or after February 14, 1978, and prior to August 21, 1978, and for which funds appropriated by P.L. 95-205 or P.L. 95-480 are used to pay the claim:
 - (a) where a physician has found, and so certified in writing to the State agency, that on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term;
 - (b) where two physicians have found, and both certified in writing to the State agency, that on the basis of their professional judgment, severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term or
 - (c) for the victims of rape or incest, if the State agency has received signed documentation from a law enforcement agency or public health service stating that:
 - (i) the person upon whom the medical procedure was performed was reported, within sixty (60) days of the incident, to have been the victim of an incident of rape or incest and
 - (ii) the report included the name, address, and signature of the person who reported the rape or incest.

4. For abortions performed on or after August 21, 1978, and for which funds appropriated by P.L. 95-205 or P.L. 95-408 are used to pay the claim:
 - (a) where a physician has found, and certified in writing to the State agency, that on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient;
 - (b) where two physicians have found, and certified in writing to the State agency, that on the basis of their professional judgment, severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term. The certification must contain the name and address of the patient. At least one of the two physicians must also certify that he or she is not an interested physician. An interested physician is one:
 - (i) whose income is directly or indirectly affected by the fee paid for the performance of the abortion or
 - (ii) who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion or

- (c) for the victims of rape or incest, if the State agency has received signed documentation from a law enforcement agency or public health service stating:
 - (i) that the person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest;
 - (ii) the date of the incident;
 - (iii) the date of the report, which must be within sixty (60) days of the incident;
 - (iv) the name and address of the victim and the name and address of the person making the report (if different from the victim) and
 - (v) that the report included the signature of the individual who reported the incident.

The continuing resolutions which made funds available for FY 1980, P.L. 96-86 signed October 12, 1979, and P.L. 96-123 signed November 20, 1979, removed the exception which allowed payment for abortions in those instances where severe and long lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians. Thus, Federal funding for abortions was prohibited except: (1) where the life of the mother would be endangered if the fetus were carried to term, and (2) for such medical procedures necessary for victims of rape or incest, when such rape or incest has been reported promptly to a law enforcement agency or public health service. Regulations implementing P.L. 96-86 were published at 42 CFR, part 441, on October 26, 1979. These regulations also applied to expenditures for abortions under P.L. 96-123 because the provision in that act governing abortions was similar to the one contained in P.L. 96-86.

On January 15, 1980, the District Court for the Eastern District of New York declared the Hyde Amendment unconstitutional insofar as it precluded payments for medically necessary abortions. That decision became effective on February 19, 1980, when the Supreme Court refused to extend a stay of the district court order. Federal funding then became available for all medically necessary abortions performed on or after February 19. The Supreme Court decision of June 30, 1980, reversed the district courts decision on the constitutionality of the Hyde Amendment. The petition for rehearing filed by the plaintiffs in the McRae case delayed the effective date of the Supreme Courts decision, leaving the district court order on payments for abortions in effect. The Supreme Court denied the appellees petition for a rehearing in the McRae case on September 17, 1980, and the district courts order was vacated on September 19, 1980. Therefore, the availability of Federal funding for abortions performed after September 19, 1980, was subject to the FY 1980 Hyde Amendment restrictions; i.e., Federal funds under Medicaid were available only for abortions performed in life endangering circumstances and abortions performed in instances of promptly reported rape or incest.

On October 1, 1980, the President signed a joint resolution making continuing appropriations available for FY 1981 through December 15, 1980, or until the enactment of a subsequent appropriation. This resolution contained language which changed the conditions under which Federal funding was available for abortions under which Federal funding was available for abortions under Medicaid. During FY 1980, Federal funds were available for abortions necessary for the victims of rape or incest when the rape or incest was reported to a law enforcement agency or public health service within sixty days.

Under the FY 1981 resolution, Federal funds were available for abortions necessary for the victims of rape when the rape had been reported within 72 hours to a law enforcement agency or public health service. Federal funds were also available for abortions necessary for the victims of incest. There was no longer a reporting requirement for victims of incest. In cases of incest, Federal funding was available when the State agency had received a physicians written statement that the physician had been informed that the patient was a victim of incest. As in FY 1980, Federal funds continued to be available for abortions where the life of the woman would be endangered if the fetus were carried to term.

On June 5, 1981, the President signed the Supplemental Appropriations and Rescission Act of 1981. Under this act, Federal Financial Participation (FFP) is no longer available for abortion claims paid after June 5, 1981 for victims of rape or incest. Federal funds continue to be available for abortions where the life of the mother would be endangered if the fetus were carried to term.

Subsequent congressional measures have continued to make Federal funds available for abortions where the life of the woman would be endangered if the fetus were carried to term. See P.L. Nos. 97-51, 97-92, 97-276, 97-377, 98-107, 98-139, 98-619, 99-107, 99-154, 99-434, 99-464, 99-465, 99-491, 99-500, 99-591, 100-202, 100-436, 101-166, 101-517, 102-170 and 102-394.

Effective October 1, 1993, as part of Public Law No. 103-112, the Health and Human Services Appropriation Bill, Congress passed a revision of the Hyde Amendment pertaining to Federal funding of abortions under the Medicaid program. Federal funding (FFP) is now available for abortions performed to save the life of the mother or to terminate pregnancies resulting from rape or incest when the claim for such an abortion is paid by the State on or after October 1, 1993. Please note that it is the date that the State pays the claims and not the date of the service which determines the availability of FFP.

Subsequent congressional measures continued to make Federal funds available for abortions performed to save the life of the mother or to terminate pregnancies resulting from rape or incest when the claim for such an abortion is paid by the State on or after October 1, 1993. See P.L. 103-333, 104-134, 104-208, 105-78, and 105-277.

Effective November 13, 1997, as part of the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 1998, P.L. No. 105-78, Congress passed a revision of the Hyde Amendment pertaining to Federal funding of abortions under the Medicaid program. As enacted in section 509, the provision stated:

- (a) None of the funds appropriated under this Act shall be expended for any abortion.
- (b) None of the funds appropriated under this Act shall be expended for health benefits coverage that includes coverage of abortion.
- (c) The term "health benefits coverage" means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

Section 510 continued as follows:

- (a) The limitations established in the preceding section shall not apply to an abortion
 - (1) if the pregnancy is the result of an act of rape or incest or
 - (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- (b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).
- (c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

As with the language in effect since October 1, 1993, the revised Hyde Amendment provided for funding for abortions if the pregnancy is the result of an act of rape or incest, but added new language precluding payment for any "health benefits coverage" that includes abortions other than those specifically permitted by the terms of the Hyde Amendment. Therefore, a managed care provider or organization that provides abortions in addition to those reimbursed under the Hyde Amendment pursuant to a contract or other arrangement with the Medicaid agency are not eligible for any Federal funding for any of the services covered by that contract or arrangement. If a state wishes to reimburse managed care providers or organizations to provide additional

abortions, it must do so under a separate contract or arrangement using monies unrelated to Federal, state or local Medicaid matching dollars. However, this limitation does not restrict the ability of any managed care provider to offer abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a states' or locality's contribution of Medicaid matching funds).

These requirements remain in effect pursuant to the Omnibus Consolidated and Emergency Supplemental Appropriations for FY 1999, Public Law 105-277, which was enacted on October 21, 1998. However, Public Law 105-277 also contained revised language to extend the restriction of funds to any trust fund. The revised subsections read:

- (a) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for any abortion.
- (b) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for health benefits coverage that includes coverage of abortion.

All of these restrictions have been continued in the Department of Health and Human Services Appropriations Act 2000, Public Law 106-113, enacted and effective on November 29, 1999; the Omnibus Consolidated and Emergency Supplemental Appropriations Act For Fiscal Year 2001, enacted and effective on December 21, 2000 and the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2002, Public Law 107-116, enacted and effective on January 10, 2002.

The government is currently operating under a continuing resolution. The statute regarding Federal abortion funding limitation has remained unchanged since the FY 2002 appropriations act.

Part II - Data on Medicaid Financed Abortions

Following the implementation, on February 14, 1978, of regulations which resulted from the Hyde Amendment, a specific reporting procedure was developed for reporting information on Medicaid financed abortions. Data is reported quarterly by the States on the numbers of abortions and allowable abortion-related expenditures. National totals, by Federal fiscal year, of expenditures and numbers reported for Medicaid abortions are displayed on the attached table. The table reports data for the period February 14, 1978 through September 30, 2002.

Since February 14, 1978, 62,208 Medicaid financed abortions have been reported by 56 jurisdictions through September 30, 2002. Total Medicaid expenditures, including Federal and State shares, for abortions have been \$19,978,686 during the period February 14, 1978 through September 30, 2002. Six jurisdictions (American Samoa, Hawaii, New York, the Northern Mariana Island, Puerto Rico, and the Virgin Islands) have not claimed Federal funds for abortions.

Of the 56 jurisdictions which reported for the period October 1, 2001 through September 30, 2002 (FY 2002), 14 jurisdictions claimed FFP under the Medicaid program for 122 abortions at a cost of \$124,064 including both Federal and State shares. By comparison, 14 jurisdictions claimed FFP under the Medicaid program in FY 2001 for 123 abortions at a cost of \$211,317 including both Federal and State shares. Of the 122 abortions claimed in FY 2002, 92 were due to endangerment to the life of the mother, 26 were due to rape and 4 were due to incest.

All abortion claims are subject to review by regional office staff. All claims found not to meet the applicable Federal criteria for FFP will be either withdrawn by the State or disallowed by Centers for Medicare & Medicaid Services (CMS).

CMS has not collected information on the number of abortions provided to Medicaid recipients where the State did not claim FFP, or on the number of Federally financed Medicaid abortions prior to the implementation of the regulations on the Federal financing of abortions on February 14, 1978.

The abortion data in the attached table reflects the most current information available as of January 1, 2002. Because States submit revised abortion claim data, the data contained in this report may differ with information contained in reports previously issued.

**TOTAL NATIONAL EXPENDITURES AND NUMBERS REPORTED FOR
MEDICAID ABORTIONS BY FEDERAL FISCAL YEAR
FEBRUARY 14, 1978 - SEPTEMBER 30, 2002¹**

	<u>EXPENDITURES</u>	<u>NUMBERS</u>
TOTALS	\$ 19,978,686	62,208
FY 1978 2/	\$ 502,546	1,335
FY1979	\$ 1,130,955	3,675
FY1980	\$ 6,983,816	33,625
FY1981	\$ 4,362,651	17,495
FY1982	\$ 447,066	783
FY1983	\$ 723,719	856
FY1984	\$ 767,908	893
FY1985	\$ 1,252,482	865
FY1986	\$ 139,066	232
FY1987	\$ 127,539	91
FY1988	\$ 211,307	135
FY1989	\$ 224,192	120
FY1990	\$ 102,827	71
FY1991	\$ 187,360	92
FY1992	\$ 269,160	168
FY1993	\$ 411,799	223
FY1994	\$ 459,111	235
FY1995	\$ 348,589	205
FY1996	\$ 307,320	231
FY1997	\$ 289,732	281
FY1998	\$ 175,636	126
FY1999	\$ 92,872	114
FY2000	\$ 125,652	112
FY2001	\$ 211,317	123
FY2002	\$ 124,064	122

¹ Data for this report are taken from the 64-9 forms submitted by the Medicaid Jurisdictions as part of their Quarterly Statement of Expenditures. This report reflects the most current information available as of January 1, 2001. Because the States submit revised Abortion Claim Data, the data contained in this report may differ from information contained in reports previously issued.

² Data from FY 1978 are only for the period from February 14, 1978 through September 30, 1978.

WITNESSES

	Page
Carbonell, J. G	1867
Duke, Betty	531
Fauci, Anthony	531
Gerberding, Julie	531
Hauer, Jerry	531
Horn, W. F	1203
Scully, T. A	703
Thompson, Hon. Tommy	1
Weems, K. N.....	703, 1203
Zerhouni, Elias	531

INDEX

Department of Health and Human Services

	Page
Abstinence Education	86
Administration on Aging Funding	75
AIDS	39
Audiology	100
Autism	24
Bioshield	17
Bioshield Initiative	83
Cancer Research	43
Children's Hospitals Graduate Medical Education (GME)	96
Clinical Laboratory Improvement Amendments Regulations	67
Compassion Capital Fund	72
Congressional Justification	103
Departmental Website	43
Disease Research	30
Disproportionate Share Hospitals (DSH)	22, 41
Drug Imports	101
Evaluation Tap	79
Faith-Based and Community Initiatives	61
Faith-Based Services	50
Food Safety/Bioterrorism	98
Full-Time Equivalent	51
Head Start	33
Head Start Program	68
Health Care	17
Health Disparities	39
Health Professional Training	95
Health Professions	38
Healthy Start	19
HHS Budget	18
HHS Command Center	13
HIV Prevention Initiative	87
Homeland Security	80
Homelessness	63
Hospital Preparedness	31
Hospital Technology	20, 24
Influenza	81
Influenza Pandemic	16
Information Technology	20
Lapse of Funding	60
LIHEAP	92
Medicaid and Head Start	26

	Page
Medicaid Reform	28
Medicaid Ride Pay	41
Mental Health	42, 92
Mentoring Children of Prisoners	74
Minority AIDS Report	40
National Sample Survey of Registered Nurses	65
Newborn Hearing Screening	47
Newborn Screening	96
NIH Budget	17
Nursing Shortage	65
Opening Statement	2
Pediatric Rule	100
Prescription Drugs	36
Prevention	18
Samaritan Initiative	64
Severe Acute Respiratory Syndrome (SARS)	14
Smallpox	89
Smallpox Immunization	22
Strengthening Public Health System	32
Strengthening State and Local Infrastructure	14
Steps to a Healthier U.S.	90
Substance Abuse Treatment	48
Title VII Health Professions Funding	95
Transfer of Funds	76
WISEWOMAN	45, 91
Youth Media Campaign	19

Department of Health and Human Services Bioterrorism Hearing

Academic Health Centers	614
Advance Research Program	655
Anthrax Vaccine	676
Benchmarks	693
Biodefense	617
BioShield	621
Bioterrorism	648
Bioterrorism Response Planning	587
BioWatch	622, 625
CDC Research Projects on Bioterrorism	600
Centers for Public Health Preparedness	627
Chemical Terrorism Program	636
Continuing Education	645
Coordination with Intelligence Community	595
Countermeasures Against Bioterrorism	674
EIS Program	642
Emergency Communications System	630
Emergency Preparedness Funding	658
Environmental Public Health Response to Terrorism Program	633
Extramural Facilities Construction	677
Federal Response	691
Food Safety/Bioterrorism	686
Hand-Held Devices	639
Health Alert Network (HAN)	637
HHS Internal and External Communication and Coordination	579
Homeland Defense	616

	Page
Homeland Security Act	599
Hospital Preparedness	619
Hospital Surge Capacity	598
Laboratory Response Network	581
Mental Health Aspects of Preparedness	610
Mental Health Component	590
Monitoring Awarded Funds	591
Non-Biodefense Benefits	646
Occupational Health	669
Opening Statements:	
Dr. Elias Zerhouni, NIH	559
Dr. Elizabeth James-Duke, HRSA	571
Dr. Julie Berberding, CDC	547
Mr. Jerome Hauer, PHEP	537
Oversight of State and Local Preparedness Grants	611
Planned FY 2003 and FY 2004 Biodefense Initiatives	603
President's Biosense Initiative	624
Project Bioshield.....	535, 583
Psychological Consequences of Terrorism	589
Public Health System	682
Publishing Research Papers.....	592, 653
Research and Development Activities	534
Rocky Mountain Laboratory	644
Severe Acute Respiratory Syndrome (SARS).....	593, 650, 689
Smallpox:	
Immunization Guidance	692
Vaccination	684
Vaccination Program	643
Vaccine	585
State and Local Hospital Preparedness	701
State and Local Public Health Preparedness	532
Strategic National Stockpile.....	580, 644
Syndromic Surveillance Systems	625
Terrorism Preparedness Programs	661
Upgrading State and Local Public Health Preparedness	613

Centers for Medicare and Medicaid Services

Alternative Mechanisms for ALJ Reviews	773
Appeals Reform	709
Benefits Improvements and Protection Act	771, 773
Benefits of Medicare Hearings Transfer	762
California Waiver	727
Clinical Quality Control Regulations	732
CMS Accomplishments	705
CMS Discretionary Budget	705
CMS Performance Goals	776
CMS Workloads	704
Congressional Justification	780
Cost of Medicare Hearings Transfer	762
Defensive Medicine	728, 770
Disease Management.....	754, 766
Drug Coverage	778
Fastest Growing Cost Items	746
Fraud, Waste, and Abuse	747

	Page
FTE Reduction	751
Health Insurance Portability and Accountability Act (HIPAA)	750
Healthcare Integrated General Ledger and Accounting System (HIGLAS)	751
Healthy Start, Grow Smart	704, 752
Home Health Care	745
Implementation of Sections 521 and 522	772
Improve Medicare Hearings Process	763
Information Technology FTEs	759
Malpractice Reform	743
Medicaid	779
Medicaid Costs	747
Medicaid Pharmacy Services	749
Medicaid Reform	729
Medicaid Waivers	735
Medicare & You	752
Medicare Appeals Reform	753, 760
Medicare Claims	756
Medicare Hearings Transfer	762
Medicare Reform	758
Moratorium on Hiring New ALJs	763, 772
Nursing Home Administration	764
Nursing Home Quality Initiative	753
Opening Statement	706
Outlier Payments	731, 742, 744
Pediatric Dentistry	765
Portable X-Rays	727, 732
Prescription Drug Spending	744
Prescription Drugs	746, 769
President's Management Agenda	756
Qualified High-Risk Insurance Pools	751
Skilled Nursing Facilities	749, 764
State Survey & Certification and Research FTEs	757
Survey and Certification	756, 757, 759, 774
Toll-Free Telephone Information	753

Administration for Children and Families

Adoption:

Adoption Awareness	1262
Adoption from Foster Care	1261
Information Dissemination to At-Home Child Care Providers	1237
Child Poverty Reduction	1258

Child Support Enforcement:

Child Support Enforcement	1260
Child Support Enforcement Proposals, 2003	1217
Child Support Enforcement Proposals, 2004	1218

Community Services:

Community Services Block Grant.....	1243, 1263
Community Services Block Grant Audits	1228, 1229
Community Services Programs	1222
Compassion Capital Fund	1246, 1264
Duplicative Programs	1251
Independent Living Training Vouchers	1241

Head Start:

Children Served by Head Start	1225
-------------------------------------	------

Head Start—Continued	
Children with Disabilities	1239
Head Start	1252, 1267
Head Start Assessment	1220
Head Start Budget Request	1240, 1270
Head Start Delivery System	1222
Head Start Professional Development	1221
Head Start Program Design	1215
Head Start Proposals	1219
Head Start Quality	1235
Head Start Teachers	1216
Montgomery County Preschool Program	1238
Pre-Literacy Skills in Head Start	1230
Research on Head Start	1234
Ripple Effect of Head Start	1217
State Participation in Head Start	1225
Testing in Head Start	1232
Individual Development Accounts	1249
LIHEAP:	
LIHEAP	1255
LIHEAP Funding	1270
LIHEAP Hot Weather Assistance	1272
Mentoring Children of Prisoners	1245, 1266
Office of Refugee Resettlement:	
Office of Refugee Resettlement	1250
Refugee Services	1224, 1267
Unaccompanied Alien Children	1224
Youth:	
Positive Youth Development	1258
Strengthening the Parent-Child Bond	1260
Promoting Responsible Fatherhood and Healthy Marriage	1247
Promoting Safe and Stable Families	1244
TANF Charitable Choice	1256
Unauthorized Programs	1215
Welfare Reform	1254

Administration on Aging

Aging "One-Stop Shop" Centers	1884, 1896
Aging Research	1882
Aging Services	1867
Building Partnerships	1869
Caregiver Support	1893, 1901
Challenges and Goals	1870
Community-Based Care	1883
Congressional Justification	1904
Core Programs	1869
Demand for Services	1888
Eldercare Locator	1896
Health Promotion	1902
Healthcare Service Delivery System	1890
Institutional Care	1884
International Aging	1882
Long-Term Care Ombudsmen	1889
"Money Follows the Individual" Rebalancing Demonstration	1892
Nutrition Programs	1893

	Page
Opening Statement	1871
Pension Counseling	1897
Prescription Drugs	1899
Program Evaluations	1887
Program Models	1886
Public Outreach	1883
"Rebalancing" Long-Term Care.....	1868, 1889
Senior Centers	1884
Steps to a Healthier US	1892
White House Conference on Aging	1898



Opening Statement	1371
Patient Counseling	1397
Prescription Drugs	1399
Program Evaluations	1397
Program Models	1398
Public Outreach	1398
"Sustaining" Long-Term Care	1399
Senior Centers	1399
Steps to a Healthier Life	1399
White House Conference on Aging	1399

CMS LIBRARY



3 8095 00016496 8